

Barriers and Facilitators to Mental Health Services among Bhutanese Refugees in
Central Ohio:

A Mixed Methods Study

Thesis

Presented in Partial Fulfillment of the Requirements for the Degree Bachelor of Social
Work in the Undergraduate School of The Ohio State University

By

Eliza Soukenik

Undergraduate Honors Program in Social Work

The Ohio State University

2020

Thesis Committee

Arati Maleku, Ph.D., Advisor

Abstract

Mental health concern is a consequential issue facing resettled Bhutanese refugees in the United States. Without early intervention, mental illness among this vulnerable population may lead to lifelong negative outcomes impacting the welfare of the individual, the family, and the entire community. Research shows that mental health outcomes are closely tied to barriers to mental health services among the Bhutanese refugee community. The current study seeks to identify barriers and facilitators to mental health services among the Bhutanese Refugee community in the Central Ohio region. Using a two-phased explanatory sequential mixed methods design, this study aims to understand the concept of mental health from the Bhutanese refugee community context, symptoms and experience of mental health issues, cultural context of mental health, and barriers and facilitators to accessing and utilizing mental health services. Using an explanatory sequential design, data were collected through a quantitative survey ($N=40$) and a virtual focus group discussion ($N=6$). Findings of the study showed that that mental health is a significant problem among Bhutanese refugees. There is a persistent cultural stigma surrounding mental health in the Bhutanese community (92%). The community's understanding of mental health is tied to traumatic historical experiences, which affects cultural stigma around the issue of mental health and those who experience mental health. Although, the community experiences mental health collectively, it remains unexpressed and unaddressed due to the cultural stigma surrounding mental health. The barriers to seeking mental health services include: cultural barriers, but also persistent gaps in culturally responsive services. Facilitators to seeking and utilization of services is for medical providers to go beyond the traditional counseling methods of treatment. Findings provide several implications. Mental health education needs to be culturally grounded using culturally appropriate methods. Providers need to look at the root cause of trauma tied to identity and historic experiences and not just at the symptoms of mental health. There needs to be culturally responsive holistic interventions that focus on healing rather than treatment of symptoms at a community level. Providers should understand the cultural and historic context of this population in order to effectively provide tailored mental health services.

Dedication

I dedicate this research to subgroups of immigrants, refugees, migrants, and those with precarious legal status who are struggling with mental health symptoms in silence. It is my hope that this study will inform, educate, and enlighten communities and service systems to facilitate mental health service utilization among refugees. I hope this study will be an attempt to help alleviate the struggles and eradicate the stigma surrounding mental health and the utilization of mental health services.

Acknowledgments

I would really like to thank Dr. Arati Maleku for being unconditionally supportive and patient with me throughout this entire process. There was no way I could have done this without her knowledge, expertise, and guidance. I would like to thank all the staff at the Bhutanese Community of Central Ohio (BCCO) for welcoming me into their community, helping me collect data, and translate surveys on top of their already heavy caseload. I would like to thank my field placement supervisor, Cat Gossman, at CRIS for allowing me the time and space to work on my thesis. I would also really like to thank Ms. Jennie Babcock, BSW Director and the Ohio State University College of Social Work for always supporting the ideas and goals of their social work students. I am extremely grateful for the stipend provided to complete this thesis that required translations and bi-cultural interpreters.

Table of Contents

Abstract.....	1
Dedication.....	2
Acknowledgments.....	3
List of Tables.....	6
List of Figures.....	7
Chapter 1. Introduction.....	8
Literature Review.....	10
Refugees in the United States.....	10
Mental Health of Refugees.....	11
Identified Barriers and Facilitators to Mental Health Services.....	14
Bhutanese Refugees in the United States.....	16
Mental Health of Bhutanese Refugees.....	16
Purpose and Aims of Study.....	19
Chapter 2. Theoretical Framework.....	20
Acculturation Perspective.....	20
Healthcare Service Utilization Perspective	21
Chapter 3. Methods.....	22
Research Design.....	22
Participant Recruitment.....	23
Institutional Review Board (IRB) Approval.....	23
Data Collection.....	24
Phase I: Quantitative Data Collection (Surveys).....	24
Phase II: Qualitative Data Collection (Virtual Focus Group Discussion).....	25
Data Analysis.....	29
Quantitative Data Analysis.....	29
Qualitative Data Analysis.....	30
Chapter 4. Results.....	32
Part 1: Quantitative Results.....	32
Perceptions of Mental Health.....	32
Mental Health Experience.....	34
Cultural Stigma and Mental Health.....	35
Mental Health and Coping Mechanisms.....	36
Support Seeking and Coping Mechanisms.....	37
Access and Utilization of Mental Health Services.....	38
Barriers.....	38
Facilitators.....	39
Part 2: Qualitative Results.....	40
Theme 1: Community Understanding of Mental Health.....	41
Theme 2: Mental Health and Culture of “Inexpression”.....	41
Theme 3: Cultural Ways of Coping with Mental Health Issues.....	43
Theme 4: Trauma, Cultural Stigma, & Mental Health.....	44
Theme 5: Mental Health Services and Utilization in Central Ohio.....	45
Barriers.....	45
Facilitators.....	47

Chapter 5. Discussion.....	49
Integration of Quantitative and Qualitative Results.....	49
Community Understanding of Mental Health	50
Mental Health and Culture of “Inexpression”	50
Mental Health and Cultural Ways of Coping.....	51
Mental Health, Trauma, and Cultural Stigma.....	52
Mental Health Services and Utilization in Central Ohio: Barriers and Facilitators.....	53
Social Work Implications.....	54
Limitations.....	55
Conclusion.....	56
References.....	58
Appendices.....	61
Appendix 1: My experience as a researcher.....	61
Appendix 2: IRB approval.....	62
Appendix 3: Survey Instrument.....	63
Appendix 4: Focus Group Discussion Guide.....	67

List of Tables

Table 1: English proficiency.....	27
Table 2: Focus Group Discussion Demographics Table.....	28
Table 3: Translation of themes.....	29
Table 4: Total mean scores for GAD-7 And PHQ-9.....	35

List of Figures

Figure 1: Explanatory Sequential Mixed Methods Research Design.....	22
Figure 2: Age Distribution.....	26
Figure 3: Gender Distribution.....	26
Figure 4: Place of Birth.....	26
Figure 5: Do you think members of the community experience mental health?.....	33
Figure 6: What does mental health mean to you?.....	33
Figure 7: Do you experience mental health problems?.....	34
Figure 8: Is there stigma surrounding mental health within the community?.....	35
Figure 9: If experiencing mental health problems what are you more likely to do?.....	36
Figure 10: Are there mental health services in your area that fit your needs.....	37
Figure 11: Are these services close (easily accessible).....	37
Figure 12: Coping Strategy Indicator Scale showing mean scores.....	38
Figure 13: Barriers to accessing mental health services.....	39
Figure 14: Facilitators to accessing mental health services.....	40

Chapter 1

Introduction

Currently, the world has witnessed the largest refugee crisis in human history, where 70.8 million people were forcibly displaced due to persecution, conflict, violence, or violations of human rights at the end of 2018, the highest number ever recorded by United Nations Refugee Agency (UNHCR, 2019). Refugees are forced to flee their country of origin due to many reasons such as, war, conflict, persecution, climate change and so forth and survive a long resettlement challenge in a new country. This road to refugee resettlement and inclusion is not easy and involves multifaceted layers of trauma from pre-arrival, arrival, and post arrival, which impact the mental wellbeing of the refugee population. The stressors of resettlement contribute to the detriment of the population's wellbeing and create conflict between cultural and western concepts surrounding mental health and/or mental health interventions (Mills, 2012). Further, the racial and cultural diversity among the refugee population also comes with varying beliefs surrounding mental health and service utilization. Thus, one size fits all approaches to mental health interventions do not work across the diverse needs and capacities of resettled refugee sub-populations.

Literature exploring mental health service access and service utilization among the refugee population has found that refugee populations are an at-risk subpopulation in the United States for emotional, health, and behavioral challenges (Derr, 2016). These challenges are exacerbated by migration experience, resettlement challenges, acculturation experiences as well as structural barriers to health and human services that create negative views on mental health services (Mills, 2012). Literature exploring

post-resettlement stressors that impact refugee mental health affirm that the lack of utilization of mental health services are related to barriers attributed to language, transportation, income, lack of access to services and lack of cultural understanding from providers (Williams & Thompson, 2011). Studies show that refugees are more likely to experience severe mental illness, substance abuse, higher burden of post-traumatic stress disorder, major depression, and suicidal ideation given the pre and post migration challenges they encounter (Porter & Haslam, 2005). One such population is the Bhutanese refugee population, resettled in the United States, which has been the subject of considerable mental health discussion. Although there are high rates of mental illness among this population, there are low service utilization rates due to direct and indirect barriers experienced by the Bhutanese refugee population (Adhikari, Yotebieng, Acharya, & Kirsch, 2015). Studies that explore the cultural context of this population are much needed to inform culturally tailored intervention for this population.

My study therefore, seeks to broaden the cultural understanding of mental health among the Bhutanese refugee population, a refugee sub-population, disproportionately affected by the burden of mental health. In order to promote the social and mental wellbeing of this vulnerable population, my study seeks to: (a) explore the cultural understanding of mental health, cultural expression of mental health symptoms, and cultural ways of coping, and (b) examine barriers and facilitators to mental health services among the Bhutanese community in central Ohio. Findings of the study will help inform service providers to implement culturally tailored services that will address the unique needs of this refugee population. In order to set the context of the study, what follows is an overview of the literature on refugees in the United States, the

context of Bhutanese refugees in the United States and barriers and facilitators of mental health services.

Literature Review

Refugees in the United States

According to U.S. law, a refugee is a person who is unwilling or unable to return to his or her home country because of a well-founded fear of persecution due to race, membership in a particular social group, political opinion, religion, or national origin; this definition is derived from the United Nations 1951 Convention (An Overview of U.S. Refugee Law and Policy, 2020I). The United States became a member of the Convention in 1968 and then passed the Refugee Act of 1980 in response to resettling Indochinese refugees following the Vietnam War (An Overview of U.S. Refugee Law and Policy, 2020). This act was incorporated into U.S. law and provides legality for the U.S. Refugee Admissions Program today (An Overview of U.S. Refugee Law and Policy, 2020).

The flow of refugees has been increasing worldwide. The number of forcibly displaced people has been rising, therefore increasing the number in the United States (An Overview of U.S. Refugee Law and Policy, 2020). According to the United Nations High Commissioner for Refugees (UNHCR), there were 9.9 million refugees in 2012, and in 2017 there were 19.6 million-- showing a drastic increase. According to the U.S Department of State, BPRM Refugee Processing Center, in 2013, 69,926 refugees were admitted to the United States and the Refugee Admissions Ceiling was 70,000, in 2016, 84,994 and the ceiling was 85,000, in 2019, 30,000 refugees were admitted and the ceiling was 30,000, and in 2020, thus far 3,219 refugees have been admitted and

the Refugee Admissions Ceiling is 18,000 (U.S. Department of State, BPRM Refugee Processing Center).

The refugee admission into the U.S. have declined under the Trump Administration beginning in 2017 (An Overview of U.S. Refugee Law and Policy, 2020). Trump signed an executive order that suspended the entire U.S. refugee admissions program for 120 days and indefinitely suspended admissions of the entry of Syrian refugees into the country (An Overview of U.S. Refugee Law and Policy, 2020). The administration lowered the FY 2017 refugee admission ceiling from 110,000 to 50,000, then to 45,000 in 2018, and then again to 30,000 in 2019 (An Overview of U.S. Refugee Law and Policy, 2020).

In 2019, the top two origin groups of refugees were the Democratic Republic of Congo (DRC) and Burma; they represented 64 percent (Blizzard & Batalova, 2019). Approximately 12 percent of all arrivals during the first months of 2019 were from Ukraine, making them the third- largest group (Blizzard & Batalova, 2019). Refugees from Burma were the largest group resettled to the United States over the past decade; 138,861 (21 percent) of the 648,482 refugees admitted between 2009 and 2019 (Blizzard & Batalova, 2019). The next largest group were from Iraq, at 20 percent (127,478), then the Bhutanese at 14 percent (90,841 individuals) (Blizzard & Batalova, 2019). Ohio resettles 4 percent from these groups (Blizzard & Batalova, 2019).

Mental Health of Refugees

Refugees experience unique stresses, poverty, and prejudice (Greenberg & Fejzic, 2019). They are an at-risk subpopulation in the United States for emotional, health, and behavioral challenges (Greenberg & Fejzic, 2019). Mental health related

issues include: stress associated with immigration and resettlement, acculturation (language, economics, education, health care, and religion), encounters with bias, discrimination, and racism, and numerous traumatic experiences (Greenberg & Fejzic, 2019). The stresses involved in immigration and resettlement exacerbate mental health difficulties-- creating and contributing to stressors (Greenberg & Fejzic, 2019). Refugees are more likely to experience somatic complaints, sleep problems, behavioral problems in children, substance abuse, severe mental illness, and suicidal ideation (APA resolution on Immigrant Children, Youth, and Families, 2016; Working with Immigrant-Origin Clients, 2013; Working with Refugee Children and Families, 2009). These experiences often paralleled with acculturation issues can further mental health issues, causing them to become more complex (Greenberg & Fejzic, 2019).

Acculturation is a multifaceted process that is psychological and behavioral (Greenberg & Fejzic, 2019). It occurs in stages and is the process of adaptation when two cultures come together; refugee families learn to function in new cultures and must find adequate resources for basic needs (Greenberg & Fejzic, 2019). These many adjustments to a new society as well as managing the burden of challenging financial situations prove to be difficult for former professionals or highly educated from their country of origin who may experience a difficult time finding employment of their profession or education is not recognized by the U.S. (Greenberg & Fejzic, 2019). This often results in added stress and exacerbates mental health issues due to loss of status, economic hardship, and psychological stress (Greenberg & Fejzic, 2019).

Rates of mental health disorders, like depression, post-traumatic stress disorder (PTSD), and anxiety disorders are higher among refugee populations than the general

population (Hameed, Sadiq, and Din, 2018) due to experiences prior to migration, trauma and war exposure, increases the vulnerability to mental health disorders (Hameed, Sadiq, and Din, 2018). Mental health issues such as depression and anxiety, may manifest due to stressors linked to post-migration; separation anxiety, finding employment, adapting culturally and linguistically and resettling in an unfamiliar country (Hameed, Sadiq, and Din, 2018). These mental health disorders are linked to traumatic events, prior and post migration, like violence, harassment, and a lack of basic needs (Hameed, Sadiq, and Din, 2018). Due to refugees unique traumatic experiences, their mental health is thought to be distinct from those of other populations that face trauma (veterans and sexual assault victims) (Hameed, Sadiq, and Din, 2018).

A large contributing factor to mental health challenges include lack of access to basic needs for long periods of time, instability, and consistent violence (immigrant and refugee). Refugee populations that experience traumatic events often are more vulnerable to increased symptoms if they experience another traumatic event (Hameed, Sadiq, and Din, 2018). A study done involving refugees from Iran, the Balkan region, and Turkey; all participants were diagnosed with PTSD (Schock et al, 2016). Groups that experienced a new significant life event displayed increased avoidance behavior, which may be a mechanism for these individuals to avoid re-experiencing their past trauma (Schock et al, 2016). Stressful events affected symptoms more than traumatic life events, displaying that new life events resulted in an increase in PTSD symptoms (Schock et al, 2016).

Identified symptoms of depression in refugees vary and can include changes in sleep pattern, weight, exhibiting a depressed mood, lack of energy, loss of interest,

feelings of worthlessness, lack of focus, recurrent thoughts of death and suicide (Hameed, Sadiq, and Din, 2018). Symptoms of PTSD include hyperarousal, avoidance, and intrusion (Hameed, Sadiq, and Din, 2018). It is associated with traumatic experiences; war, being held prisoner/hostage, torture and physical violence, serious accident/explosion, death of a loved one, sexual harassment, and serious illness (Hameed, Sadiq, and Din, 2018). Symptoms of anxiety include irritability, fatigue, restlessness, excessive worrying, having trouble sleeping and focusing (Hameed, Sadiq, and Din, 2018).

Identified Barriers and Facilitators to Mental Health Services

Research suggests that there is an underutilization of mental health services among refugees in the United State, despite equal to higher rates of mental health symptoms (Fitzgerald, 2017). Social, linguistic, economic, clinical severity, cultural differences in symptom presentation, and systemic discrimination are identified challenges to accessing mental health services (van der Boor and White, 2020 & Fitzgerald, 2017). Legal entitlement also plays a role; the structure of health systems, determined by national policy, determines the availability of services, insurance needs, extent of coverage, impacting the ability to access services by subgroups of migrants (van der Boor and White, 2020).

Research stresses that cultural factors like, stigma and norms regarding mental health contribute to lower service utilization (Derr, 2016). Stigma is the most frequent factor as a barrier to services, while traditional beliefs were identified as a barrier to formal care (Derr, 2016). Stigma and privacy concerns surrounding mental health stems from the individual and community (van der Boor and White, 2020). It is embedded in

preconceived notions of what mental health looks like and how symptoms are portrayed-- creating internalized and silenced mental health symptoms due to the shame from stigma (van der Boor and White, 2020). This creates a fear to seek help and services from medical providers, especially stemming from family pressures as well as a gender hierarchy (van der Boor and White, 2020). This furthers the concerns surrounding confidentiality; the fear that if services are accessed and confidentiality is not kept this may lead to stigmatization from the community (van der Boor and White, 2020).

Linguistic barriers such as, lack of adequate translation services is a major obstacle when accessing mental health services (van der Boor and White 2020). The inability to communicate effectively with providers often leads to fear and a feeling of uncertainty around outcomes of health (van der Boor and White, 2020). Interpreters used as a translation of services can play a role in the community creating concerns confidentiality (van der Boor and White, 2020). There are also concerns surrounding interpreters interpreting inaccurately like; omitting material, impeding interpersonal dynamics, passing judgment, or sharing unsolicited personal attitudes and advice (van der Boor and White, 2020). Structural barriers like economics contribute to disparities of service utilization (Derr, 2016). Lack of insurance, cost of services, and accessibility are barriers to the use of mental health services among migrant subgroups (Derr, 2016). The location of the medical center, the ability or inability to pay for transportation, scheduling off work for appointment, and finding care for children contribute to the hardships of navigating the structural barriers to accessing mental health services (van der Boor and White, 2020). These economic stressors determine the choice of services

and whether services are utilized (van der Boor and White, 2020). Attitudes and perceived discrimination by healthcare providers led to feelings of rejection (van der Boor and White, 2020). There is a feeling that concerns were not taken seriously and disregarded by providers (van der Boor and White, 2020).

Bhutanese Refugees in the United States

The Bhutanese refugees are an ethnically and linguistically Nepali minority group, who were forced to flee Bhutan in the early 1990s (Evans, 2010; Hutt, 2003). Most settled in refugee camps established by the United Nations High Commissioner for Refugees in Nepal, where, despite the group's cultural and historical ties to the country, they never received citizenship (Chase & Sapkota, 2017; UNHCR, 2017). In 2007, a large-scale resettlement campaign was launched, and today the majority of Bhutanese refugees have resettled in Europe, North America, New Zealand, and Australia. The total population has grown to approximately 110,000, with over 80,000 residing in the US (Shrestha, 2015). In Ohio alone, approximately 8,467 Bhutanese refugees were initially resettled in the last decade (Adhikari et al., 2015). Currently, central Ohio is home to approximately 23,427 Bhutanese refugees (Adhikari et al., 2015). Due to secondary and tertiary migrations from other states, it is expected that this number will continue to increase over the next five years with the projected population of 30,000 to 40,000 Bhutanese refugees living in central Ohio (S. Pyakurel, personal communication, Jan 20, 2017).

Mental Health of Bhutanese Refugees

Once resettled, Bhutanese refugees face many hardships from adjusting to a new environment, lack of employment, reliable social services, and language barriers to

identity concerns and other psychosocial stressors (Ellis et.al, 2016). Mental health is a major concern among this population. Recent studies conducted by the Center for Disease Control and Prevention and the Ohio Mental Health & Addiction Services (OMHAS) suggest alarming rates of anxiety symptoms, posttraumatic stress disorder (PTSD), depression, suicide, and prevalence of substance misuse (Cochran et al., 2013). Specifically, Bhutanese refugees experience different mental health problems, including PTSD, as well as elevated risk of somatoform pain disorders, anxiety, and other mental health problems (Mills, Singh, Roach, & Chong, 2008; Van Ommeren et al., 2001). They are about 10 times more likely to experience PTSD than citizens of host countries in similar age groups (Fazel, Wheeler, & Danesh, 2005).

In addition, the CDC (2012) has documented a high number of Bhutanese refugee suicides. A psychological autopsy conducted among Bhutanese refugees whose family died by suicide in the US suggested that many of the victims experienced the suicide of a friend or family member (Ao et al., 2012). The study in Ohio found higher rates of attempted suicide, high levels of exposure to trauma and a fairly low rate of self-identified mental health conditions, revealing unmet mental health treatment need either masked or under reported (Adhikari, Yotebieng, Acharya, & Kirsch, 2015). The study also found high incidence of daily alcohol use (higher than 20%), tobacco use (25% of respondents were current cigarette smokers and 23% used smokeless tobacco), dual tobacco use, nicotine addiction to smoking and smokeless tobacco, and exposure to a neighbor or friends who died by suicide—highlighting the critical need in behavioral health interventions through culturally and linguistically appropriate services (Adhikari, Yotebieng, Acharya, & Kirsch, 2015). In addition, the Bhutanese refugees

also have low mental health help-seeking behavior, where less than a third (28%) of the Ohio study group were interested in seeking help from a mental health professional or medical practitioner (Adhikari, Yotebieng, Acharya, & Kirsch, 2015). Mental health concerns remain a huge stigma within the Bhutanese community, and is often unaddressed and unrecognized due to gaps in service delivery and utilization.

In general, research shows that refugees are often unwilling or unable to utilize health services despite being eligible for a numerous range services (Burger, 2014; Fortuny & Chaudry, 2011; Pereira et al., 2012). Accessing health services are a challenge for the refugee population given persistent barriers that include: language, financial stress, gaps in culturally tailored services, lack of knowledge about services as well as cultural beliefs (Maleku et al, 2018; Oliver, 2014). Language skills impact the extent to which refugees can communicate their concerns to health professionals (Asgary & Segar, 2011). This increases the likelihood of poor communication between providers and patients (Fitzpatrick, Villarruel, & Porter, 2004). A common result of language barriers is a failure to seek preventive services to address existing conditions (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). Further, insufficient financial capital is an obstacle to obtaining services (Maleku et al, 2018). Without access to transportation, lack of legal documentation and/or lack of literacy skills necessary to obtain a driver's license create challenges to accessing necessary services (Maleku et al, 2018). Lack of financial capital affects health insurance and corresponding coverage, which this population is less likely to acquire (Kaiser Family Foundation, 2013). Awareness regarding alternative methods of accessing medical coverage is not widespread either (Oliver, 2014).

When it comes to mental health, the stigma associated with mental health subsequently leads to refraining from seeking adequate treatment in order to avoid negative labels associated with mental illness (Saechao et al., 2012). In addition to the challenging process of acculturation experienced by refugees entering the United States (Asgary & Segar, 2011), the social and environmental factors that include provisions and delivery of services create additional challenges to accessing and utilizing services. This is primarily due to western beliefs of human services utilization, which may differ greatly from refugee populations (Maleku et al, 2018). A recent report in the central Ohio region showed that although human service providers are putting an effort to provide mental health services, there are significant gaps in providers' understanding of cultural belief systems (Maleku et al., 2018). This lack of cultural understanding presents significant challenges to provide culturally responsive services. The proposed study therefore, seeks to broaden the cultural understanding of mental well-being experienced by Bhutanese refugee population to inform culturally tailored mental health interventions in the central Ohio region.

Purpose and Aims of Study

The proposed study seeks to broaden the cultural understanding of mental well-being experienced by Bhutanese refugee population to inform culturally tailored mental health interventions by: (a) exploring the cultural definition of mental health, cultural understanding of mental health symptoms and cultural ways of coping, and (b) examining barriers and facilitators of mental health service utilization among the Bhutanese refugee population among the Bhutanese community.

Chapter 2

Theoretical Framework

This study uses acculturation and healthcare utilization perspectives as the guiding theoretical framework for the study.

Acculturation perspective

The Theory of Acculturation focuses on the cultural and psychological aspects of acculturation (Berry, 2005). Acculturation is the process of cultural and psychological change that results due to contact between two or more cultural groups and individual group members (Berry, 2005). At the group level, there is change in cultural practices, social structures, and institutions (Berry, 2005). At the individual level, changes involve a person's behavior (Berry, 2005). Groups and individual members participate in intercultural contact, which may cause potential for conflict (Berry, 2005). These conflicts might need negotiation to achieve outcomes that are adaptive for differing groups (Berry, 2005). Acculturation involves large group and individual differences on how the process of acculturation proceeds, regarding integration, assimilation, and separation and marginalization (Berry, 2005). There are differences in how stress is experienced and how well they adapt socioculturally and psychologically dependent upon individuals and groups (Berry, 2005). These aspects of acculturation in general, should be acknowledged in policies of multiculturalism (Berry, 2005). While seeking ways to accommodate multicultural groups creates challenges, it will incorporate ways of valuing features of all cultures and support participation of groups in society (Berry, 2005). Acculturation in a new culture also impact utilization of services.

Healthcare service utilization perspective

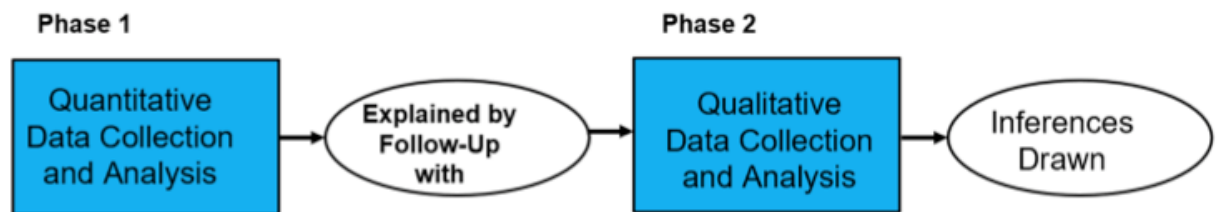
Anderson's Behavioral Model of Health Services Use was developed to assist the understanding of why individuals and families use health services (Anderson, 1995). It is used to define and measure equitable access to healthcare, and to support developing policies to promote equitable access to healthcare (Anderson, 1995). The model examines the demographics and economic characteristics of the individual, family, or group unit to suggest the likelihood people will need health services and whether services can be accessed (Anderson, 1995). It takes into consideration social structure and social networks that may impact health beliefs, attitudes, values, and knowledge that people have about health and services (Anderson, 1995). The model has been subject to insurmountable application and alteration in hopes of developing an inclusive model. When applied to the acculturation perspective, healthcare service utilization perspective informs a holistic health service utilization in the forced migration context.

Chapter 3

Methods

Research Design

The study I used an explanatory sequential mixed-methods design in two phases (Figure 1; Creswell, 2015). The first phase of the study included quantitative data collection through a structured survey instrument. The survey method allowed for a broad scope of data to be collected regarding mental health inequities among Bhutanese community members residing in Central Ohio. Preliminary findings of the survey data helped inform the qualitative data collection in the second phase, which was collected through a virtual focus group discussion. The qualitative data helped garner in-depth cultural understanding of mental health that also helped to further explain the quantitative findings.



Explanatory Sequential Mixed Methods Design

Adapted from (Creswell, 2015)

Figure 1: Explanatory Sequential Mixed Methods Research Design

The use of explanatory sequential methods design in this study utilized the qualitative data as a way to explain the quantitative results (Creswell, 2015). Further, the quantitative data helped shape the qualitative data collection process. By examining

the results of the quantitative analysis prior to the qualitative determined what results will need further exploration, and what questions needed to be asked to participant voices during the next phase (Creswell, 2015). As such, the two phases build upon each other, to garner a comprehensive understanding of the issue in question. The use of a mixed methods design was important to this study to allow for more in-depth understanding of the issue using quantitative and qualitative methods than using one method alone. Further, the use of mixed methods have been shown to be important, particularly among culturally vulnerable populations to help garner in-depth cultural understanding of specific issues.

Participant recruitment

Data collection included both quantitative data and qualitative data collection in collaboration with two community-based organizations. Through Ohio State University College of Social Work, I was connected to Community Refugee and Immigration Services (CRIS), a local refugee resettlement agency in central Ohio as a part of my BSW internship. At CRIS, I was able to recruit participants via word of mouth, flyers, and by connecting with community leaders. Community leaders at CRIS then connected me to the Bhutanese Nepali Community of Central Ohio (BCCO), a community-based organization in Columbus. This site was the key recruitment site for collecting data for my study, since their service population was the Bhutanese community in central Ohio.

Institutional Review Board (IRB) approval

The IRB approval (see IRB approval in Appendix 2) was received from The Ohio State University Office of Responsible Research (Study# 2019B0535). All informed consents were received before data collection.

Data Collection

Phase I: Quantitative Data Collection

A 30-item survey instrument (see survey instrument in Appendix 3) was administered to participants at BCCO ($N=40$). The survey was kept short to avoid survey fatigue, respect the participants' time, and garner more completed responses. The quantitative data focused on three key sections where participants self-reported on: demographics, understanding of mental health and mental health experience, and mental health utilization. The demographics section included variables such as age, gender, religion, length of stay in United States and Ohio, education, employment, and the language proficiency of participants to describe the sample population.

The mental health section focused on understanding of mental health and how members of the community defined mental health. It also included standardized scales: Generalized Anxiety Disorder (GAD-7), Patient Health Questionnaire (PHQ-9), and Support Seeking Coping Indicator Scale to garner more information on anxiety, depression, and coping mechanisms respectively. The mental health utilization, included questions around barriers and facilitators of mental health services. The survey also included some open-ended questions to further garner more information regarding individual opinions, and viewpoints on mental health experience and barriers and facilitators to mental health services. Surveys were administered both in English and Nepali based on the participants' preference and English proficiency level. Interpreters were on site to aid in the facilitation of the survey. A \$10 Kroger gift card were given to participants as a small incentive for their time spent on completing the survey.

Phase II: Qualitative Data Collection (Focus group discussion)

After the completion of Phase I, qualitative data was collection in Phase II. I had initially planned to conduct a focus group discussion at CRIS, but due to COVID-19 situation, I had to make an IRB amendment for a virtual focus group discussion using the OSU Zoom platform. I used a focus group guide with open-ended questions (see Appendix 4) to conduct the focus group discussion. Questions included topics around community definition and understanding of mental health, prevalence of mental health, cultural beliefs and cultural coping mechanisms (positive and negative), and barriers and facilitators to accessing mental health services. Follow-up questions were asked as the discussion evolved. The focus group participants were emailed a virtual Amazon gift card of \$25 once the discussion was completed.

Sample

Survey Sample. Adult Bhutanese refugees residing in Central Ohio between the ages of 20-50 years of age were included in the study. This sample allowed for the inclusion of diverse Bhutanese refugee participants irrespective of gender, age, and/or caste groups within the group. This sub-population diversity also provided opportunities to examine within group similarities and differences.

The quantitative survey sample included 40 total participants ($N=40$). Almost 57.50% of participants were between 20-30 years of age (Figure 2). The median annual income was between \$31,000 and \$40,000. Approximately 55% of the study participants identified as males and 45% identified as females (Figure 3).

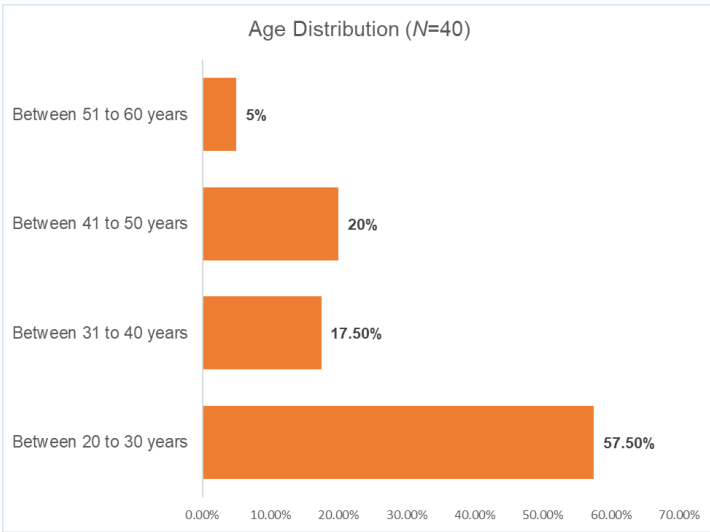


Figure 2: Age Distribution

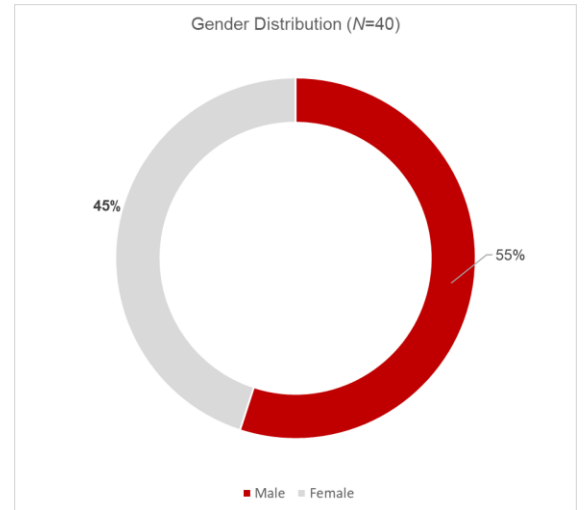


Figure 3: Gender Distribution

Out of the total participants, 60% of participants were born in Bhutan and 37.5% were born in Nepal (Figure 4).

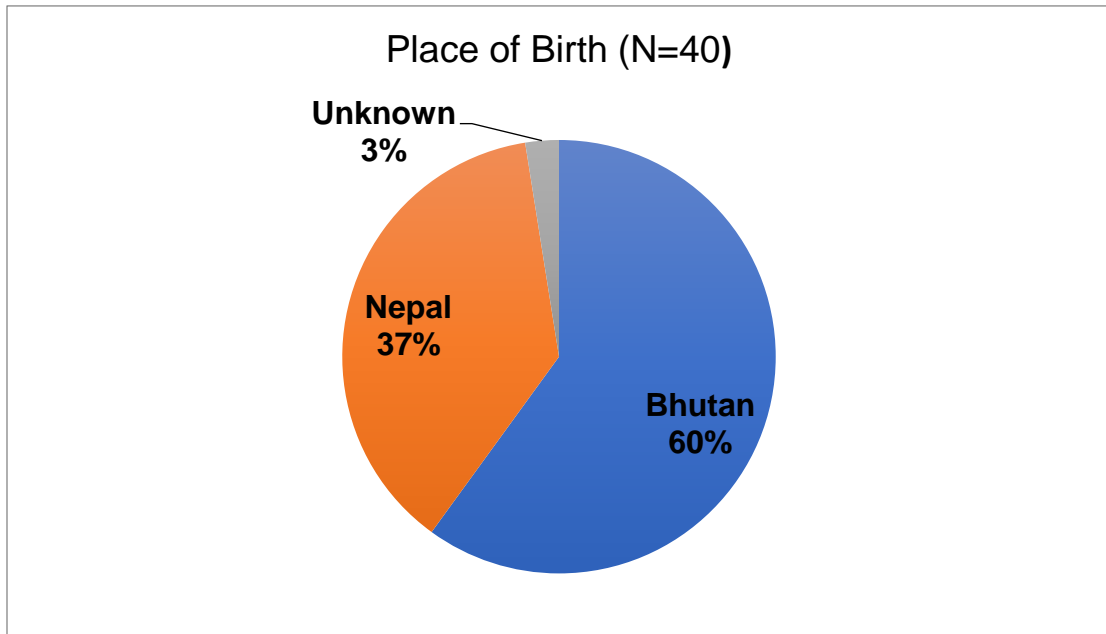


Figure 4: Place of Birth

The English proficiency of participants varied: 37.5% of participants reported to have excellent English-speaking levels, about 40% reported to have good listening skills, about 42% reported good reading skills and 42% reported to have good writing skills (Table 1).

Table 1: English proficiency

English Proficiency Levels	Speaking f(%)	Listening f(%)	Reading f(%)	Writing f(%)
Very Poor	5(12.5%)	4(10%)	5(12.5%)	5(12.5%)
Poor	1(2.5%)	1(2.5%)	1(2.5%)	1(2.5%)
Fair	6(15%)	4(10%)	2(5%)	2(5%)
Good	13(32.5%)	16(40%)	17(42.5%)	17(42.5%)
Excellent	15(37.5%)	15(37.5%)	15(37.5%)	15(37.5%)
Total	40(100%)	40(100%)	40(100%)	40(100%)

Focus Group Sample. The sample of the focus group consisted of a total of six participants ($N=6$). The mean age of participants was about 32 years, ranging from 20-50 years of age. There was equal distribution of male and female participants; mean length of stay in Ohio was about eight years. The participants were mostly employed full-time and represented different professions including social workers, caseworkers and managers as well as a director and a student. Demographic characteristics of the focus group participants is shown in Table 2.

Table 2: Focus Group Discussion Demographics Table

Demographic Characteristics of Focus Group participant (N=6)	
Age (<i>M, SD</i>)	Mean=31.75 years, SD=12.5
Gender	
Male	3
Female	3
Place of Birth	
Bhutan	3
Nepal	3
Highest Education	
High School/Diploma	2
College Degree	2
Graduate Degree	2
Length of Stay in the US (<i>M, SD</i>)	Mean=10 years , SD=0.816
Length of Stay in Ohio (<i>M, SD</i>)	Mean=7.75 years, SD=2.5
Employment	Full-time (4), Part-time (2)
Profession	Social worker (2); case worker (1); Case manager (1); Director (1); Student (1)

Data Analysis

Quantitative Data Analysis. SPSS software was used to enter the quantitative data from the survey. After data entry, the data was then cleaned, coded, and re-coded of variables for analysis. Univariate analyses also called descriptive statistics were used to describe the data. Since there were several standardized scales such as GAD-7, PHQ9 and support seeking coping strategy indicator, composite scores were created to calculate the cut-off point for these scales. Reliability measures were also calculated for these scales. Reliability measure, which is the Cronbach's alpha showed very high level

of internal consistency across the scales. All scales were above 0.9, showing high levels of reliability among the scales used. After the univariate analyses were conducted, excel was used to chart the data for visually demonstrating study variables.

Qualitative Data Analysis. Qualitative data was recorded and transcribed verbatim. The qualitative data was analyzed using two methods. First, the Rigorous and Accelerated Data Reduction technique—the RADaR technique—was used to reduce the data in an excel spreadsheet, and then a thematic analysis method was used to code the data in three steps of open coding (coding), axial coding (sorting) and selective coding (synthesizing). The first step was to code the data using an open coding process, the codes were then put in categories as shown in the translation of themes table and the categories were synthesized into overarching themes for the data (Table 3).

Integration of Quantitative and Qualitative Results

The results from the study will be provided in a staged approach, where the quantitative results and the qualitative results will be presented respectively. The quantitative and qualitative data will then be integrated during analysis through a weaving technique, where data will be merged based on a concept-by-concept basis (Fetters et al, 2013). The weaving technique is used when one data collection procedure (quantitative survey) informs the data collection approach of the other (qualitative focus group), by using parallel questions that cover the same themes (Fetters et al, 2013). The two databases are merged for analysis and comparison, highlighting convergent and divergent themes (Fetters et al, 2013).

Table 3: Translation of themes

Thematic Codes	Categories	Overarching Themes
Historical experience attached to mental; source of taboo; if they talk, become more isolated and stigmatized; lack of expression of mental health; loosely defined, no clear understanding, people's definition varies; no accepted definition of mental health; normalized because of unawareness; lack of Nepali terminology for "counseling"; mental health attached to day to day activities; difficult for older people to understand; difficult to switch mindset generational gap in understanding mental health;	mental health, history and cultural stigma; cultural understanding of mental health; community understanding of mental health; mental health understanding as generational due to experience of trauma	Theme 1: Community Understanding of mental health
Belief that treatment is not needed; inexpression impacts help seeking; problem is normalized; fear of expression; historic experience of counseling attached to discipline or punishment; changing historic perception of counseling difficult; unexpressive culture because of "survival mode"; no ways to communicate emotions; lack of communal support; inability to express oneself	Inexpression of mental health; inexpression of mental health and fear of expression due to historic trauma; inexpression of mental health and lack of ways to communicate experiences	Theme 2: Mental health and culture of "inexpression"
Physical movement, yoga; walking; attend religious/spiritual sites; go to a temple; need for external support from services or family unit when faced with mental health issues; religious ritual is done when "evil" is present to heal; family unites for religious/spiritual practices; household chores as form of coping among older women, a way of staying busy; use of technology to cope with mental health issues among Bhutanese youth; literature group using traditional outfits and Nepali to share experiences, groups used to form community, using literature to share emotions; women's led group to discuss mental health; form a community to share emotions, such groups are helpful for younger girls; Negative coping mechanisms are expressed (alcohol, drugs, gambling); suicide as a consequence of mental illness	Physical movement as coping mechanism and spiritual/religious experiences as form of healing with support from family unit; spiritual/religious experiences as treatment for healing; busywork as a coping mechanism (ex. chores); youth and technology as a coping mechanism, create sense of community among youth; create sense of community among youth to cope with mental health, create sense of community among youth; use of literature to share experience and emotions; create sense of community among youth to cope with mental health; Negative coping—addiction and suicide.	Theme 3: Mental health and cultural ways of coping
Experience pain from past; suicide seen as evil omen; it is not viewed as an issue the person was facing; cultural stigma; people with mental health issues viewed as incapable; men battle differing roles making them vulnerable to mental health; lack of expression of mental health; fear of stigma; older generation more accepting of mental health; someone with mental health issue viewed as different; older generation with education critical of mental health; label them as crazy; incapable; viewed generationally different; mental illness in isolation; mistrust of someone who experiences poor mental health; lack of expression; fear of stigma; mental illness as taboo; cultural mistrust; fear of being labeled; trauma from past treatment; fear of counseling or services	Mental health, history and cultural stigma; inexpression of mental health issues	Theme 4: Mental health, trauma and cultural stigma
Lack of culturally responsive counselors; misinterpretation from interpreter; lack of understanding from counselor; language barrier; lack of transportation; lack of health insurance; low income; unaware of counseling; lack of advertisement for such services; lack of culturally appropriate services; lack of Nepali representation as counselors; lack of relevant screening tools; lack of confidentiality; fear of others knowing they are seeking services; fear of being labeled; fear of administration; fear of stigma; fear of past trauma; fear of losing job due to mental illness; lose source of income; stress of acculturation process; more education needed; cultural mistrust; fear of confidentiality; fine line between seeking help and creating trust; Case management; employment; gives daily routine; increased awareness; increased education; culturally age wise appropriate material; incorporation of mental health messages from community leaders; incorporate new practices into traditional; need more mental health practitioners; bi-cultural workers; younger people seek careers in mental health field; encouragement from community leaders; the College of Social Work at OSU; increased leadership; expansion of comfort zones; culture can be changed and adapted accordingly; normalizing mental health; discuss mental health on a personal level; increase of leadership discussing mental health; more education and awareness of mental health; need to understand the root causes of problem; interventions need to be built with the cultural context in mind; interventions need to be culturally grounded; culturally appropriate services; questionnaires based on experience of a refugee; create long term approaches; gaps in current modalities of care	Barriers: Lack of culturally responsive counselors, language, and income; lack of confidentiality and fear of stigma; cultural mistrust; fear of authority) Facilitators: case management, more bi-cultural workers, cultural appropriate strategies to address mental health; sharing experiences to normalize mental health;	Theme 5: Mental health services and utilization: Barriers & Facilitators

Chapter 4

Results

The results from the study will be provided in a staged approach, where the quantitative results and the qualitative results will be first presented separately and then integrated together in the discussion section.

Part 1: Quantitative Results

The quantitative results reported on perceptions of mental health, mental health definition, and barriers and facilitators to mental health services among the Bhutanese refugee community in central Ohio.

Perceptions of Mental Health. All participants reported that mental health is important to them. Participants (87.5%) reported that community members definitely and most definitely experience mental health (Figure 5). In terms of perceptions of mental health, survey participants reported that emotional wellness (87.5%), social wellness (82.5%), and physical wellness (67.5%) were the top three factors that participants related to their understanding of mental health (Figure 6). This shows a varying understanding of what mental health means to survey participants.

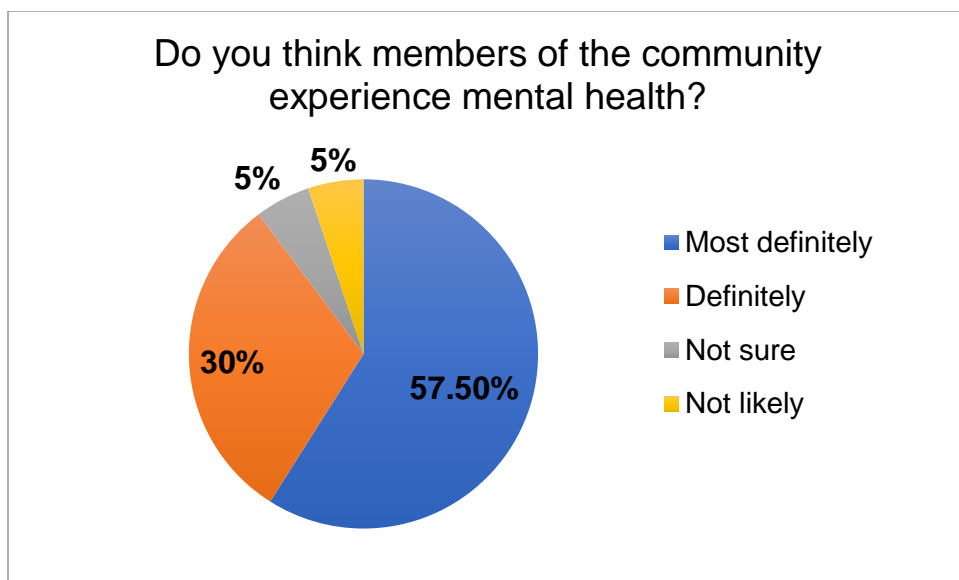


Figure 5: Do you think members of the community experience mental health?

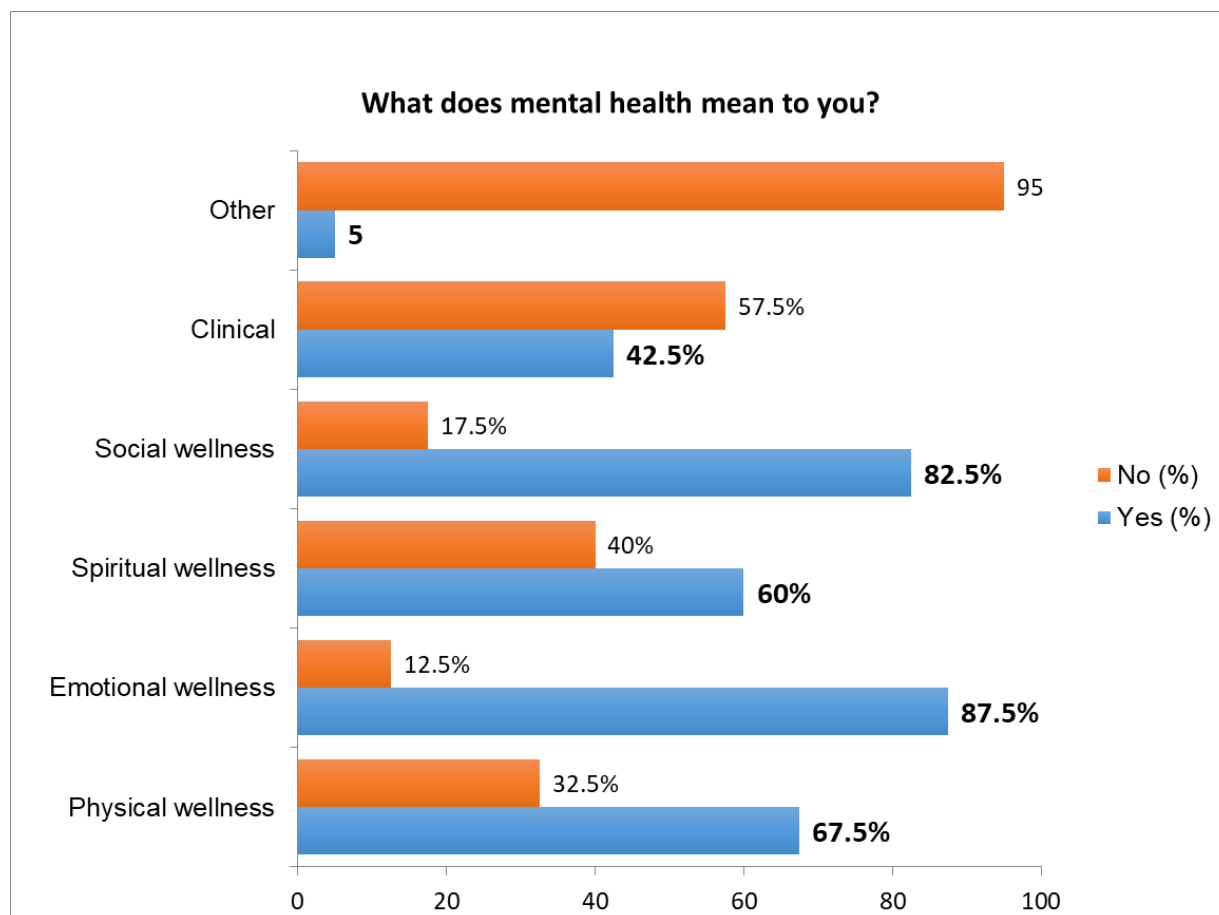


Figure 6: What does mental health mean to you?

Mental Health Experience. Regarding the experience of mental health, survey participants (42.5%) reported that they definitely and most definitely experience mental health (Figure 7).

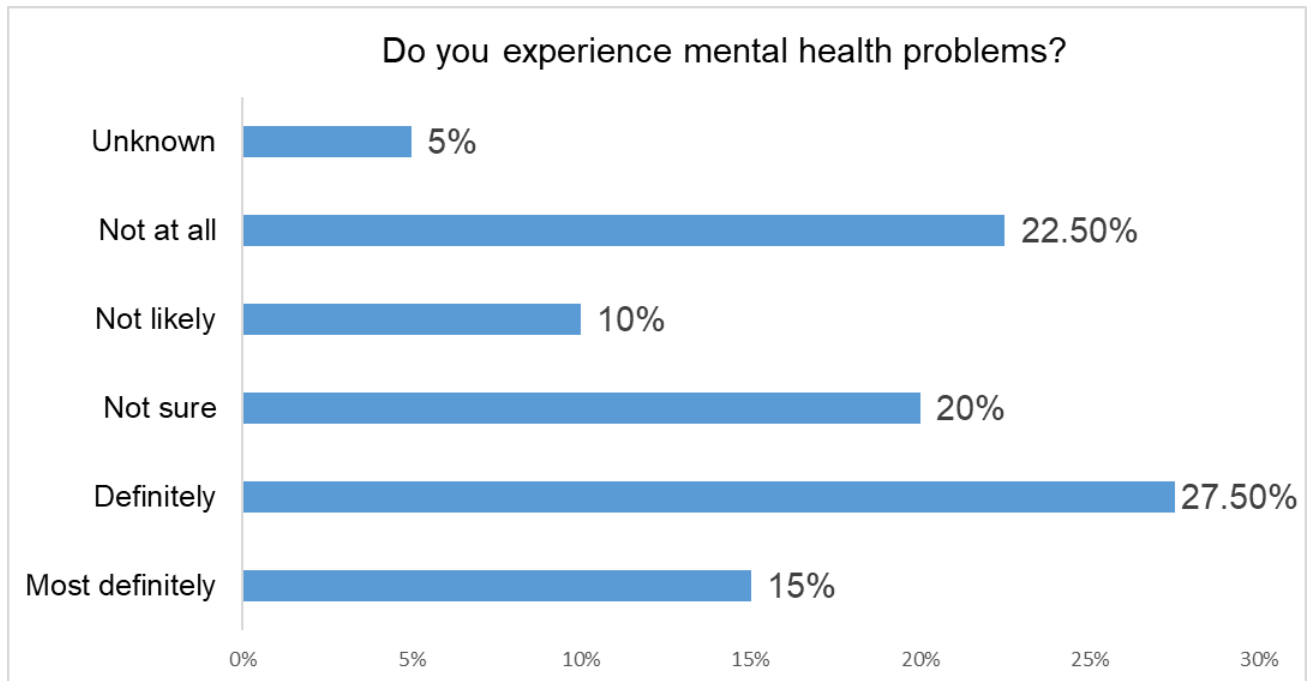


Figure 7: Do you experience mental health problems?

When examining the self-reported anxiety and depression scales: the total mean for the GAD-7 score was 5.67 with a reliability of .91, which means that participants reported generalized anxiety is at a mild level (Table 4). The PHQ-9 total mean is 14.79 with a reliability of .93, meaning that participants depression score is moderately severe (Table 4).

Table 4: Total mean scores for GAD-7 And PHQ-9

Mental Health Measure	Total Mean Score (Levels based on cut-off point)	Reliability (Cronbach α)
Generalized Anxiety (GAD-7)	5.67 (SD= 6.322), Mild	0.91
Depression Scale (PHQ-9)	14.79 (SD= 7.01), Moderately severe	0.93

Cultural Stigma and Mental Health. According to the survey participants, there is a deep cultural stigma surrounding mental health stemming from historical traumatic experiences. Participants (92%) overwhelmingly shared the prevalence of cultural stigma surrounding mental health within the community (Figure 8).

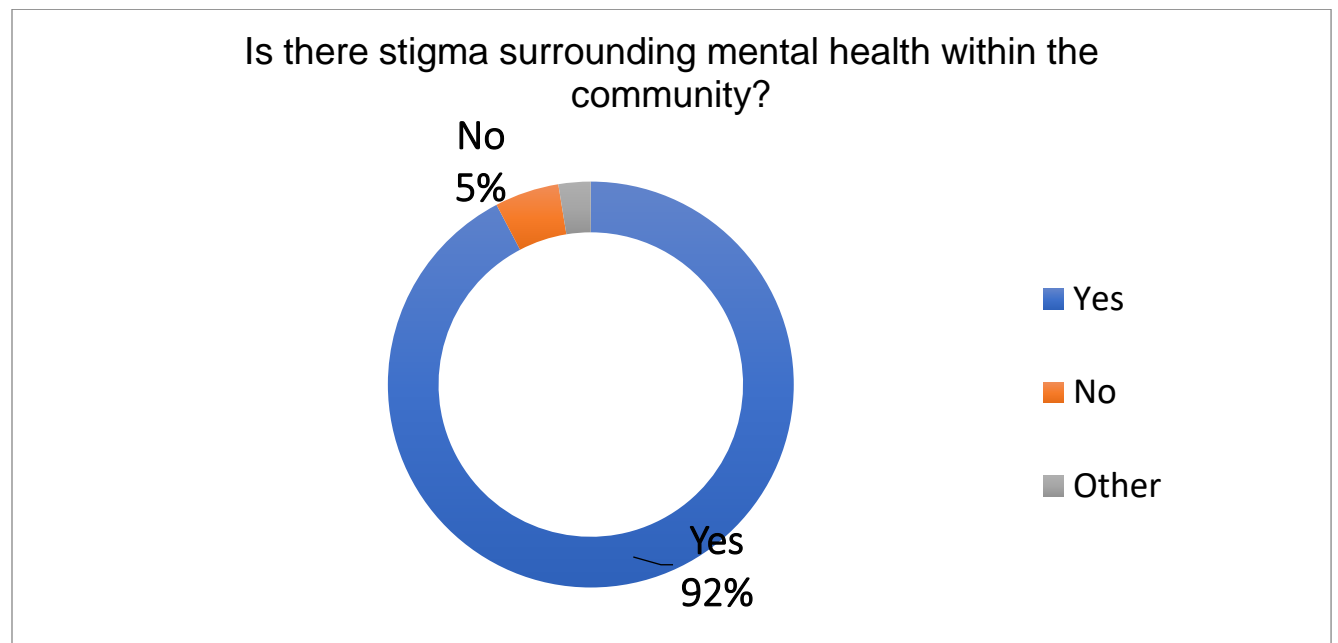


Figure 8: Is there stigma surrounding mental health within the community?

Mental Health and Coping mechanisms. Participants reported that if they were experiencing mental health they would get help from community (47.5%), get help from providers (35%), or they would not do anything (2.5%) (Figure 9).

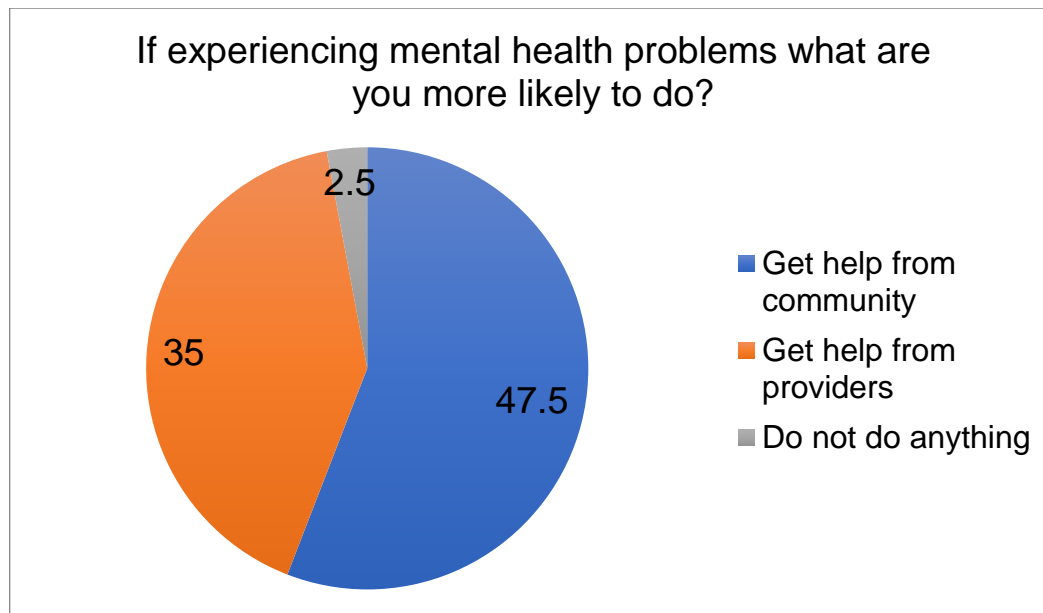


Figure 9: If experiencing mental health problems what are you more likely to do?

The survey reported that 62.5% participants stated the availability of mental health services e in their area that fit their needs, 15% said no services available, and 22.5% said that they do not know about mental health services (Figure 10). Participants shared varying perceptions on proximity and accessibility of services: 50% of participants reported that services are close and easily accessible ; 25% reported on services that are not close and easily accessible , and another 25% reported that they are not aware of services in their area (Figure 11).

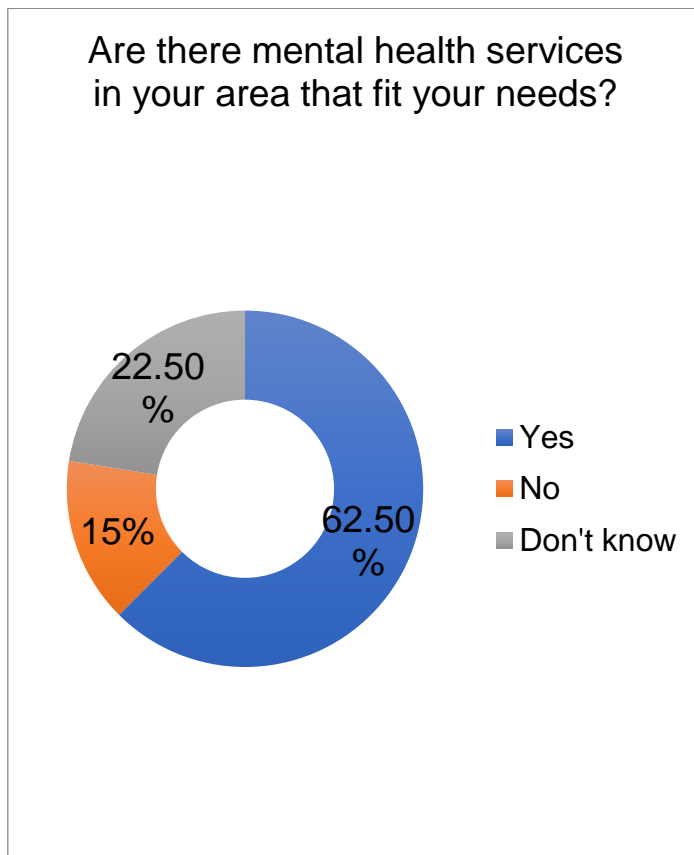


Figure 10: Are there mental health services in your area that fit your needs

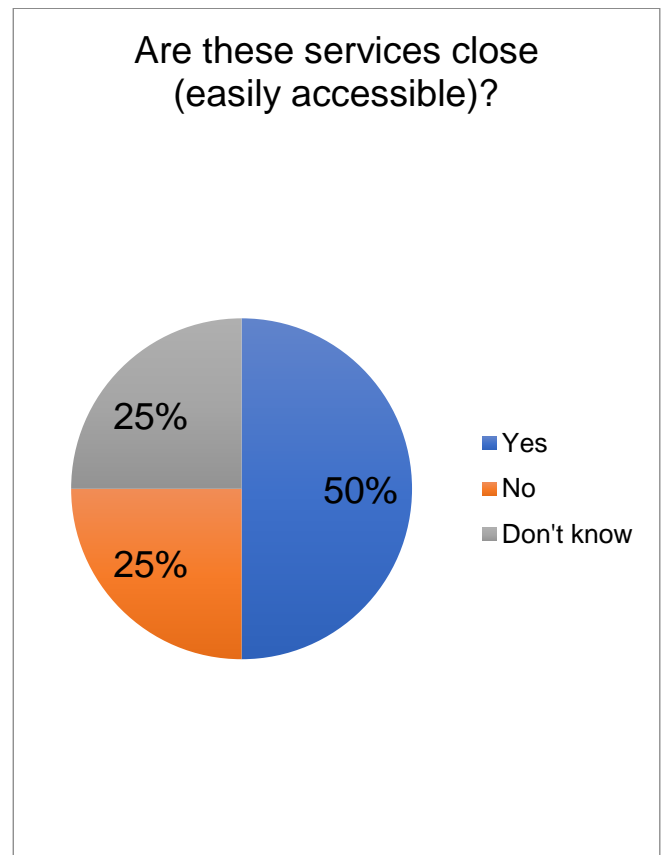


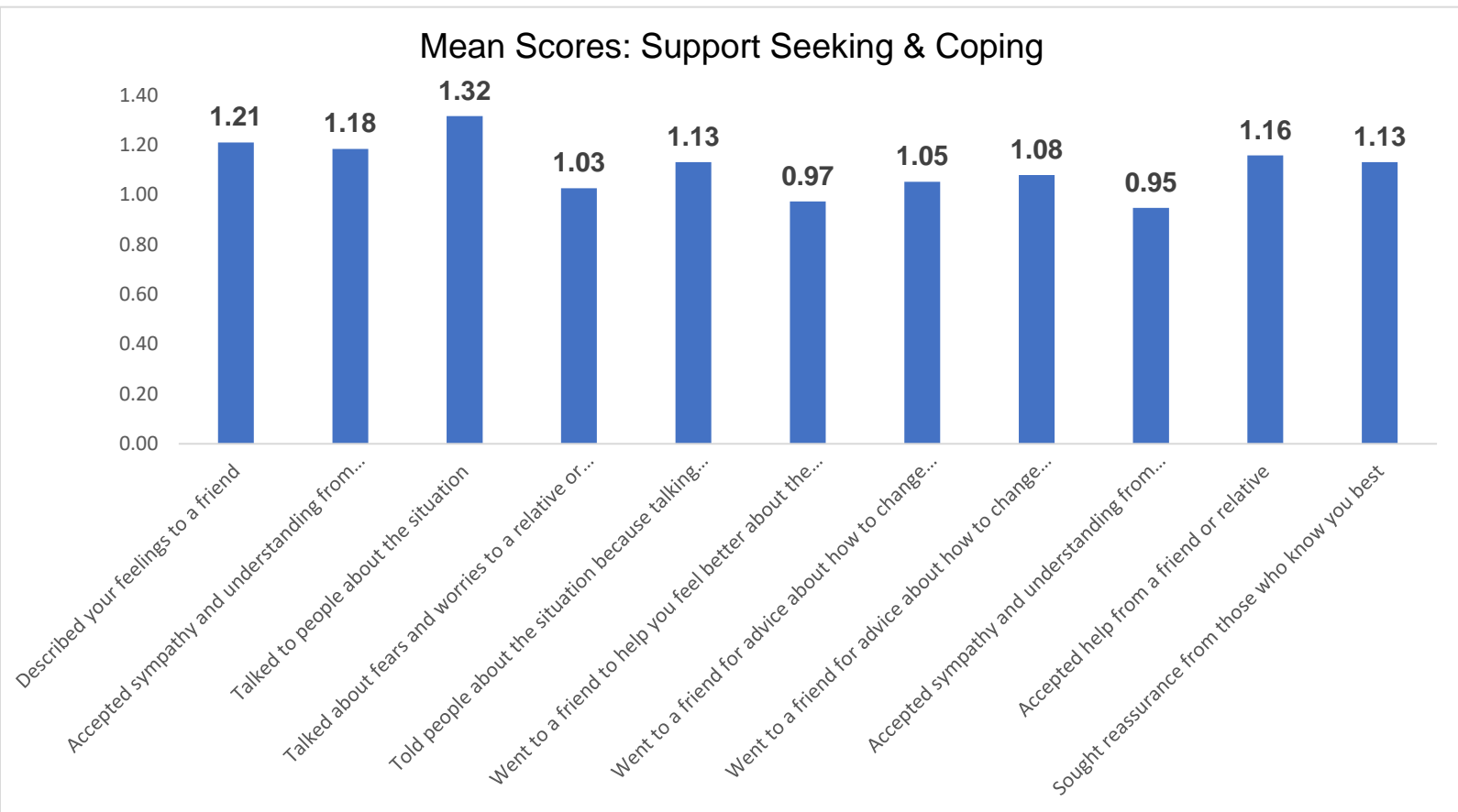
Figure 11: Are these services close (easily accessible)

Support Seeking and Coping Mechanisms.

When examining coping mechanisms, survey participants reported that 16% accepted sympathy and understanding from someone a lot of the time, 21% talked to people about the situation because talking about it made them feel better a lot of the time, 16% accepted help from a friend or relative a lot of the time, and 15% sought reassurance

from those who know them best a lot of the time (Figure 12). The survey displays that there is an outlet within the community for coping.

Figure 12: Coping Strategy Indicator Scale showing mean scores



Access and Utilization of Mental Health Services

Barriers. Survey participants reported that barriers to mental health service utilization include cultural barriers (82.5%), not aware of mental health services (67.5%), and transportation barriers (65%) as the top three barriers (Figure 13).

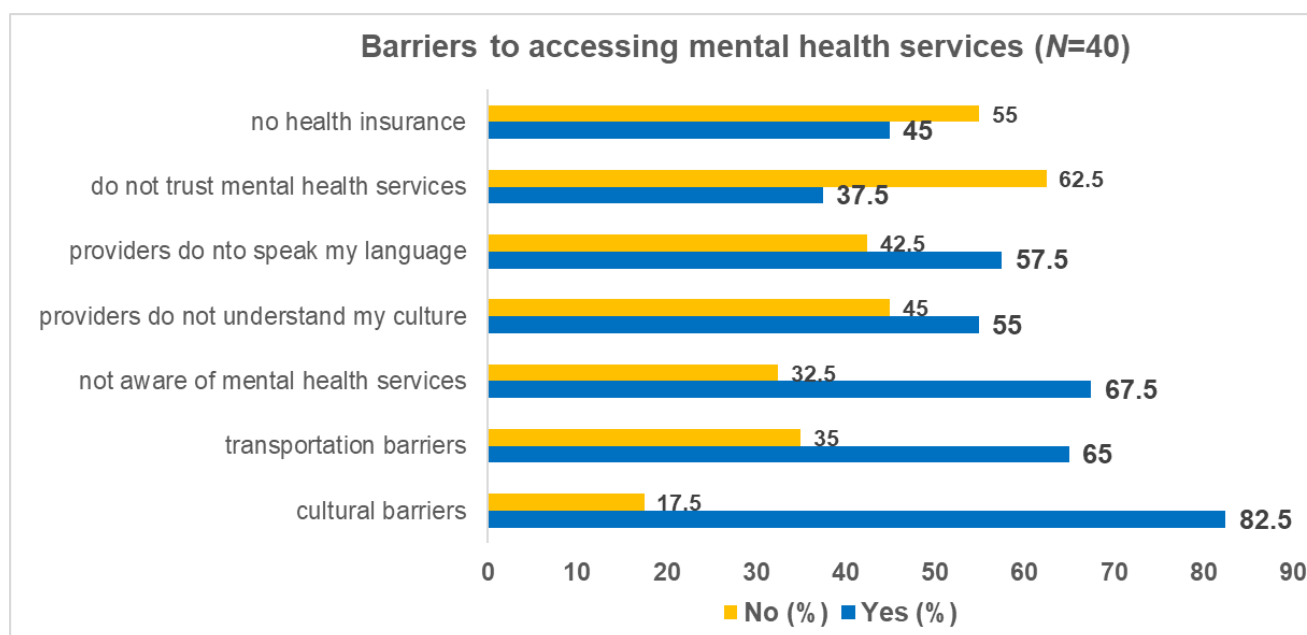


Figure 13: Barriers to accessing mental health services

Facilitators. In terms of facilitators to mental health service utilization among the community, provider speaks Nepali (80%), providers understand Bhutanese culture (72.5%), and mental health services provided by Bhutanese community (70%) were the top three facilitators to accessing mental health services among survey participants (Figure 14).

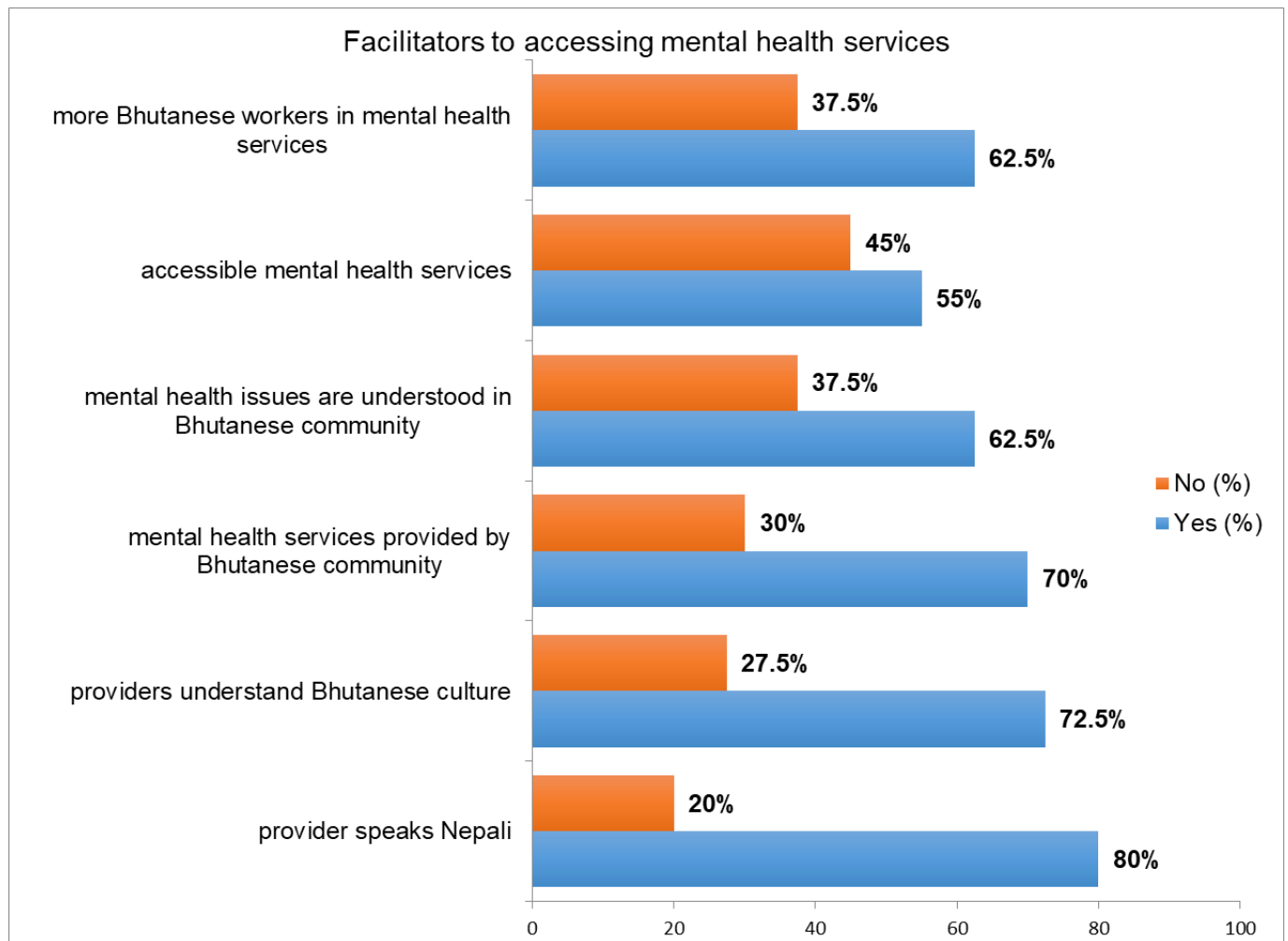


Figure 14: Facilitators to accessing mental health services

Part 2: Qualitative Results

As far as qualitative results from the focus group data, there were five salient overarching themes that emerged from data analysis: (1) community understanding of mental health; (2) mental health and culture of “inexpression”: “mental health is unexpressed”; (3) mental health and cultural ways of coping (positive and negative ways of coping); (4) mental health, trauma and cultural stigma; (5) mental health services and utilization in central Ohio: barriers and facilitators. The following section

provides detailed findings with verbatim responses grounded in community participant voices.

Theme 1: Community Understanding of mental health. Focus group participants discussed that there is no unified understanding of mental health in the Bhutanese community. Participants shared the historical experience attached to mental health and how it impacts the lack of expression of mental health within the Bhutanese-Nepali community.

What we had historically as the concept of mental health is still existing in the community despite having at least some resources around the town—it is still taken as a source of taboo and people don't like to talk about and they feel they will become more isolated and stigma [stigmatized] and they think it will make them feel more isolated by expressing themselves as mentally ill or mentally unable to do things [Focus Group Participant]

Participants shared that the community's definition of mental health is loosely defined and that there is no clear understanding of it. This stems from the history and cultural stigma of mental health within the Bhutanese-Nepali community, dating back to refugee camps and the mistreatment and misconception of those that experienced mental health issues while on location:

The whole idea of mental health is very loosely defined in our community. So, there's like not really [a clear idea]. We still haven't grasped the concept of what actual mental health looks like. So, you know, everyone has their own translation of what mental health really looks like. And we don't really have like a unified idea of what mental health really is. [Focus Group Participant]

Theme 2: Mental health and culture of “inexpression”. Focus group participants discussed the lack of expression of mental health within the Bhutanese-Nepali community.

Unexpressed. Mental health is unexpressed. [Focus Group Participant]

Further, the collectivist culture, where individual experiences are not given too much importance; gaps in terminologies and the refugee experience of constant survival might have contributed to the inexpression of mental health:

I think one of the issues is also just talking about our emotions— because we have always been on survival mode, we don't really think about ways to communicate how we feel. So, there really isn't a way to say—oh, I feel sad, or I feel isolated because we're so into the mindset of thinking that we're constantly on survival mode and we have been, but here it's different. [Focus Group Participant]

Participants stated there is this belief that due to the inexpression of mental health, that treatment is unnecessary. This inexpression inherently impacts the community's help seeking, or lack thereof. Their mental health inexpression is normalized, creating the notion that the community does not experience mental health issues:

They don't like to show that and they feel fearful of being exhibited. They feel if they say [mental health], we doubt something and talk to them to see if we can make a referral to certain agencies or services, they feel like seeking services is not an appropriate way for treatment—as they don't consider that because back home, culturally, there was no way of treating mental health in that concept, especially living in a refugee camp. Refugee camp did not have resources of providing mental health counseling to people. When you say counseling in our community, I think that means a different thing because counseling back home is more like a punishment. You know, when you say “counseling” –in refugee camp, it means you're going to the administrative section of the camp and you're getting some sort of strong advice in terms of discipline. [Focus Group Participant]

The inexpression of mental health stems from a fear of expression due to the community's historic experience of counseling that was attached to discipline or punishment and association with authority figures that created an understanding of counseling:

If I go to counseling in refugee camp, it means like I made some mistake—I might have been using benefit illegally or I might have been treating people badly, and [that's why] I've been brought to counseling session. And so to our people, when you say "counseling"—that doesn't make sense in terms of health services or giving health advice. [To them], it literally means –somebody's going to advise me in terms of my character or in terms of my behavior—things like that, because that is how generally counseling was set up back in refugee camps. So, that concept is still there. So, to take that away from people and invade another idea—counseling is something that will provide you with some good practices that you could practice in your life— and come out of this thinking is hard to sell for them—it's a hard pill to swallow for them. [Focus Group Participant]

Theme 3: Cultural ways of coping mental health issues. Focus group participants discussed positive and negative ways the community copes with mental health. Several participants denoted physical movement, like doing yoga or walking, is often utilized as a coping mechanism.

Yeah, some people do yoga. [Focus Group Participant]

Participants discussed the role of religious and spiritual sites as treatment for healing mental health.

In my family, if we do believe there is some evil going around with any member of the family. We do religious ritual— 'graha shanti' [spiritual practice to heal the spirits and the stars]. We invite family where all the family come together and practice these religious and spiritual practices. [Focus Group Participant]

Younger participants emphasized the use of technology and social media to create a sense of community where they could share their thoughts and feelings.

Yeah, and I think for my age group, it differs because, what I've seen among my friends is like they usually talk to each other, but also, I see the lack of coping mechanisms. I think for my generation, we understand the concept of mental health. But it's more so, like, how do we deal with it? And we don't have counselors who speak Nepali and it's usually hard to get a counselor of color. So, for us, it's more so, like, what are some things that we could do to cope and one of them has just been like talking to each other like via Facebook, using FaceTime, stuff like that. But I do think that we need to kind of talk about ways to

heal also. I think for my generation, it's more. So, we understand the concept but what are some steps that we could take or what are some things that we can learn to help? So that's what I've seen. [Focus Group Participant]

Focus group participants also shared negative coping mechanisms like addiction, gambling, and suicide as a consequence of mental health.

I think so many people are going negatively—like getting addicted [to alcohol and drugs], gambling, and one of the worst-case scenario is the suicide rate, which is very high in the community. It cannot be expressed, I still believe for somebody like me and in the generation older to us, if you express it you are seen as a lunatic, like you are crazy. So it's all unexpressed, it remains unexpressed like a magma and people get distracted completely--[they take negatives routes] like addiction and alcoholism and things like that, or you [feel] you must take your life. I think that is what the practice is now. [Focus Group Participant]

Theme 4: Trauma, cultural stigma & mental health. Participants discussed the mental health history, trauma and cultural stigma regarding the impact it has on the inexpression of mental health within the community. Participants shared that people who experience mental health issues are seen as incapable; this notion heavily impacts and tests the traditional role of men who experience mental health issues.

If you're going through some mental health issue—people perceive them as someone who's incapable of doing and managing day-to-day lives. For us, especially the men in our community—they want to be the working person in the family— so like for them these kinds of issues bother them. It's kind of putting them in a vulnerable position because of mental health issue. So, a lot of times people don't want to talk about it. [Focus Group Participant]

Participants shared there is a mistrust of someone who experiences poor mental health, leaving the individual isolated from the community. There is a presence of historic trauma persistent from past treatment, creating a fear of counseling and fear of being labeled in their own community.

People who are dealing with mental health issues, how they were treated in the past—there were also a lot of hospitals and stuff that were like literally joining them and treating [people] very badly, Very poorly. So, I feel like that is also another

reason why people don't want to label themselves as having mental health issues, because then you have to go through this treatment process that is so harsh and it's just do not use them. [Focus Group Participant]

Theme 5: Mental health services and utilization in central Ohio: Barriers &

Facilitators. Focus group participants discussed the barriers and facilitators to mental health services and service utilization in central Ohio. The themes that arose identify and provide an explanation to contributing factors that impact the likelihood of mental health service usage among the community. Two specific sub-themes—barriers and facilitators— capture these issues.

Barriers. Focus group participants identified several barriers that prevent access and utilization of mental health services. These barriers include cultural mistrust, lack of culturally responsive counselors, language barriers, lack of transportation, lack of health insurance, lack of advertisement of mental health services, lack of culturally appropriate services, lack of Nepali representation as counselors, misinterpretation from interpreter, lack of relevant screening tools, fear of being labeled, fear of past trauma, and stress of acculturation process.

Not having culturally responsive counselors first of all is a big barrier, because a lot of our clients, our population they don't speak English very well or not enough to be able to express themselves fully. So a lot of times what we're doing is we are using translators or interpreters to help communicate, . Most important things are left behind, like the emotional factor when you're talking about it, all that other stuff. And that really kind of creates like I don't want to say a distrust, but like a lack of understanding between the counselor and the client and if they don't get right diagnosis, or they don't get the right treatment plan so that's a big, big barrier. I feel like that's the main one. But there are a lot of other ones as well, like, you know, transportation, health insurance, money, income, and all that other things. [Focus Group Participant]

Another focus group participant shared on the unavailability of culturally responsive services that are not in accordance to the community's understanding of mental health services:

And also, I think the other barriers are when do people feel that they need counseling. People are not aware of, like, whether or not they need counseling or whether even if there is a service that is being provided in and around the town by people. They are not aware of it. Where are those resources located? How do people know about the resource? [Focus Group Participant]

The persistent gaps in culturally responsive services—linguistically and culturally appropriate services—were highlighted by participants:

They don't have any culturally appropriate services; they keep claiming they speak Nepali sometimes, like they have Nepali staff. But those staff are limited for certain work in an agency, they are in the agency to represent the community, but they are not a counselor. They don't do the counseling part; the counseling part is done by a foreign language speaker. They use Marty, or maybe they use over the phone interpreter, that is dangerous, that is very dangerous, especially in mental health. If you are having an interpreter, which is over the phone, that is not a successful way of counseling, that is lacking that is one of the barriers of when people go. I had the experience of working with a couple of patients and then when we do our follow up for the next scheduled [appointment]. So [they say] I don't want to go that route because you know what the interpreter doesn't speak Nepali or like they will say, I don't want to go because I don't like the way my counselor is asking me these questions. Focus Group Participant]

Participants highlighted that the Bhutanese community has been in the central Ohio region for over a decade now. However, they showed their dissatisfaction on the unavailability of culturally responsive services and the community's struggle to find appropriate services that work with their cultural experiences.

Bhutanese-Nepali community in Central Ohio has been here for 10 years now. Many of the service providers are getting training on culturally competent like practices, but they're not all the so called mental health service providers are lacking that is one of the main reason why people they don't like to continue. I have a bunch of cases, my caseload who are not going back to the same

counselor. They're looking for services, but they don't want to put this in counseling why? Because there is no culturally appropriate practice, [that] they are doing, or maybe they are not really sensitive to the culture. [Focus Group Participant]

Facilitators. Focus group participants identified facilitators to utilizing mental health services among the Bhutanese-Nepali community. These include: case management, culturally appropriate education, more bi-cultural workers, and culturally appropriate strategies to address mental health. Participants emphasized the need for an increase in mental health practitioners who are bi-cultural and for younger community members to seek careers in the mental health field.

You know one another thing and again, having the opportunity of having these youngsters here in this conversation I would challenge these folks to seek a career in the mental health field. Because that's where the trust comes-- because you come from the community, you speak the language you understand the culture so you guys will play a vital, vital role. [Focus Group Participant]

Normalizing mental health within the community was highlighted as an important step that would facilitate understanding of mental health as well as utilization of mental health services among the community. The importance of leaders of the community discussing mental health on a personal level to educate and provide awareness for other community members were addressed by participants:

I think we should also start normalizing this idea of mental health. I feel like we should start talking about this more just in our personal level as well, because if they see this well to do, put together leader talking about their mental health experiences I feel like it will encourage a lot of our other folks who are dealing with the similar situations and they feel like, it is not , only them who are experiencing these things. So when they see someone you know who's managing their life pretty well, who's still achieving everything else, and talking about their mental health issues I think it will definitely encourage them to seek help to even start talking about this with their families and friends. Personally, I started talking about mental health and it is a very hard thing to talk about, because we don't want to put ourselves in a vulnerable position and we don't know what the reaction will be from the other person, but just bringing it up in

conversations with people that we meet in general. If we start talking about these things and maybe holding sessions where we bring a lot of people and they are just talking about mental health issues, I feel like that will create [normalcy]. The whole idea is to make it as normal as possible, to normalize it as much as possible. So I feel like that would be a big help to us and to this community, and building off of that. [Focus Group Participant]

The focus group participants further discussed the need to understand the root cause of mental health problems based on the culture and the need for interventions to be built within the cultural context. Participants overwhelmingly supported that interventions need to be culturally grounded and that they are culturally appropriate. They also highlighted that screening tools that reflect the refugee experience should be utilized in order to better inform long term inequities in mental health experienced by the Bhutanese refugee community.

We have a wound; we have a disease that needs surgery. But what we are doing is we're putting a band-aid on, it's not going to fix this problem. We really have to come up with a culturally appropriate intervention approach in every single refugee community. I would say Somali need to come up with theirs based on their experience. We need to come up with one based on our own experience, Iraqi need to come up with their own experience. The middle class American model that the hospitals are using is not going to work with the minority community and they need to know it. They need to know it clearly and upfront-- it is not working. We have to work to create this new approach--a new approach in addressing mental health. Otherwise, this is just all you know, first aid only. [Focus Group Participant]

Chapter 5

Discussion

Integration of Quantitative and Qualitative Results

Findings of my study corroborated that mental health is a significant issue facing the Bhutanese refugee population. Study findings showed that the community's understanding of mental health is tied to traumatic historical experiences that has largely affected cultural stigma surrounding mental health and those who experience severe mental health problems. Although the Bhutanese community experience mental health collectively, it still remains largely unexpressed and unaddressed. Findings also showed that the community uses positive and negative coping strategies to deal with mental health problems. In this chapter, the quantitative and qualitative findings will be integrated through a weaving technique, where quantitative and qualitative data will be merged based on a concept-by-concept basis (Fetters et al, 2013) to provide a comprehensive understanding of the issue in question.

The weaving technique is used when one data collection procedure (quantitative survey in my study) informs the data collection approach of the other (qualitative focus group in my study), by using parallel questions that cover the same themes (Fetters et al, 2013). As such, the two databases are merged for analysis and comparison, highlighting convergent and divergent themes (Fetters et al, 2013). Using the weaving technique, I integrate both quantitative and qualitative data by highlighting five overarching concepts from both databases: (1) community understanding of mental health; (2) mental health and culture of "*inexpression*,"; (3) Mental health and cultural

ways of coping; (4) Mental health, trauma, and cultural stigma, and (5) Mental health services and utilization in central Ohio: barriers and facilitators.

Community understanding of mental health

When analyzing perceptions of mental health within the community, survey participants reported emotional wellness, social wellness, and physical wellness as the top three factors relating to their understanding of mental health. The qualitative data showed that the meaning or definition of mental health is still evolving and that there is no unified definition of mental health in the Bhutanese community, largely due to unavailability of Nepal terminologies to describe mental health or the collectivist culture where individual expressions are not given much credence. Findings of this study corroborate prior studies that show that Bhutanese refugees' understanding of mental health is tied to experiences of is largely shameful, embarrassing, and untreatable (MacDowell, Pyakurel, Acharya, Morrison-Beedy & Kue, 2020). Prior studies show that perceptions toward seeking care are generally negative and as considered as a weakness in the Bhutanese community (MacDowell, Pyakurel, Acharya, Morrison-Beedy & Kue, 2020).

Mental health and culture of “inexpression”

Findings showed that the experience of mental health based on self-reported anxiety and depression scales, were at a mild level and moderately severe levels, respectively. In contrast, findings from qualitative data showed that it is largely unexpressed. The prevalence of mental health symptoms among the Bhutanese community has been established by prior studies. Studies showed high rates of

psychiatric morbidity, disability, and suicide among this population (Luitel et al., 2013). Despite the documented high mental health risk among Bhutanese refugees, deeper understanding of mental health issue however, has not received much attention (Vonnahme et al., 2015). Findings of this study point to deeper issues of inexpression tied to refugee experience of survival, historic traumatic experiences tied to cultural stigma and barriers of collectivist cultures that overlook individual experiences. These findings are also consistent with previous studies that showed that Bhutanese refugees stated it is unhelpful to share their suffering since all members of the community experienced the same trauma (Shannon, Wieling, & Simmelink-McCleary, 2014) and that avoidance and shame were the major reasons for not discussing refugee experiences, feelings, and emotions among this population (Shannon, Wieling, & Simmelink-McCleary, 2014).

Mental health and cultural ways of coping

Survey participants reported that they do seek help in their own ways and that they feel comfortable seeking help from friends and family. The role of family and community was found to be crucial in the Bhutanese community. Qualitative focus group members reported both negative as well as positive coping mechanisms. Study findings suggested that religious and spiritual practices were positive coping mechanisms and alcohol, substance use and suicidal ideation and attempts were deviant ways of negative coping mechanisms tied to several mental health conditions. Our findings are consistent with prior studies that show that the practice of religion as was a source of support and community, that ed cultural identity and sense of belonging

among the Bhutanese refugee community resettled in the U.S. (Benson, Sun, Hodge & Androff, 2011).

Further, common negative coping strategy among Bhutanese refugees are substance use problems (Mirza, Harrison, Chaing, Salo, & Birman, 2017). Previous research states that Bhutanese refugees reported substance use behaviors changes after immigrating to the U.S. (Mirza, Harrison, Chaing, Salo, & Birman, 2017). The acculturative stress model and assimilation/acculturations model implicates that the stress of adjusting to life in a new country and the social and legal norms of the new country drive substance use behaviors of newly resettled refugees (Mirza, Harrison, Chaing, Salo, & Birman, 2017).

Mental health, trauma, and cultural stigma

Findings showed that mental health stigma largely, stemmed from historical trauma experiences, which are very difficult to talk about. More than 90% of survey participants shared the persistent cultural stigma surrounding mental health within the community. Further, findings from qualitative data showed that there is both stigma and fear of mental health expression stemming from historical traumatic experiences. Previous research found that Bhutanese refugees reported fear contributing to difficulty discussing mental health symptoms (Shannon, Wieling, & Simmelink-McCleary, 2014). They feared being seen as crazy, being alienated from the community, being forced to the hospital, being unable to be treated, and that they may lose their jobs or housing if they show emotions or symptoms of mental health (Shannon et al., 2014). This fear stems from a history of political repression (Shannon et al., 2014). The impact of captivity and violence and the perpetual threats leave refugees disconnected and

disempowered, which results in feeling helpless and speechless (Shannon et al., 2014). Even after achieving safety, refugees are not likely to speak freely about their past and current suffering due to decades of surviving silently (Shannon et al., 2014).

Mental health services and utilization in central Ohio: barriers and facilitators

Regarding barriers to mental health service utilization, cultural barriers, not being aware of mental health services, and transportation barriers were the top three barriers listed by participants from obtaining mental health services. Qualitative data showed that community members are unaware of services around them, whether or not they needed those services. Further a lack of culturally responsive providers and services were huge barriers to mental health service utilization. Study findings corroborate previous findings, where lack of cultural awareness, language barriers, lack of capital, structural barriers, staff competence, cultural barriers, lack of community outreach, lack of community awareness, and a lack of trust of providers have been established as barriers to service utilization (Maleku et al, 2019). Findings of this study highlighted culturally responsive services, bi-cultural providers from the Bhutanese community, as well as cultural engagement and cultural methods of education as the facilitators of mental health services. These findings expand the understanding of facilitators to service utilization from prior studies that highlight cultural education for staff, transportation services, language and interpretation support, outreach strategies to raise awareness of services, increase of bicultural social workers, continuing education, and community leadership development as important facilitators for refugee service utilization(Maleku et al, 2019).

Social Work implications

The study provides several social work implications. Social workers should look at how comprehensive services can be effectively provided at micro, mezzo, and macro levels that incorporate culturally grounded methods for populations like the Bhutanese community that come from collectivist cultures. Providers need to utilize culturally appropriate methods to ensure that services are addressing the needs and stressors experienced by Bhutanese community members. These methods can be prescribed by the community themselves. So, collaboration with key informants and community leaders are essential. Given the deeper historic experiences faced by the community, providers need to look at the root cause of trauma tied to identity and historic experiences and not just at the symptoms of mental health in order to better acknowledge the reality of this community. In doing so, providers will develop a greater sense of cultural understanding and provide culturally responsive services that address the root causes of mental health among this population.

Furhter, holistic interventions that focus on healing rather than treatment of symptoms at a community- level are essential to empower the community with better prospects of building community resilience. This can be done by focusing on the social and cultural environments of community members, rather than traditional practices of medical services that might not be appropriate for communities coming from collectivist cultures. Providers should be aware of entrenched cultural stigma and take appropriate action to educate and emphasize the importance of mental health in order to eliminate the cultural stigma. Emphasis on community support and non-stigmatizing approaches that identify and address collective migration experiences and mental health stressors

should be integrated in mental health programs and services. Providers should understand the cultural and historic context of this population in order to effectively provide tailored services. Services need to be tailored to address the stressors associated with acculturation as well systematic barriers associated with service provision and delivery. Service providers should create interventions that train community members in communication strategies to give meaning and definition to mental health in order to identify symptoms and whether treatment is needed. Engagement and inclusion of newly resettled refugees into educational and social opportunities to improve the resettlement process through services and support are key to the creation of an inclusive refugee environment.

Limitations

This study has several limitations. The small sample size definitely raises generalizability questions—that findings might not be generalizable to other Bhutanese refugees out of the central Ohio region or in other places in the United States. The short data collection and study timeline attributed to smaller sample size and challenges with data collection. The COVID-19 situation was a big barrier in conducting the study in a community setting and garnering diversity of participants. There were challenges in the data collection process due to lower literacy levels of participants and language barriers. Even when conducting surveys in Nepali, participants could not read the questions, which was a barrier for data collection. While translators were used to off-set this limitation and collect self-reported data, this could have led to some biases of self-reporting in presence of the translators. Further, the data collection site mostly occurred in an open setting, which might have played a role in response biases. The nature of my

study looking at the sensitive topic of mental health in itself was a limitation as there were times participants did not want to talk about it. Further, qualitative data were transcribed verbatim, which could have contributed to translation and transcription issues impacting the meaning of responses.

Conclusion

Using an explanatory sequential mixed methods research approach, this study examined the cultural understanding of mental health and barriers and facilitators to mental health services among the Bhutanese refugee community in central Ohio. Findings of the study show that community members largely experience mental health, but do not often access mental health services. Past historical traumatic experiences and current acculturation stress contribute to mental health issues among the community. The study revealed several barriers and facilitators to mental health service utilization, largely attributing to cultural understanding and culturally responsive interventions. Providers need to understand the inherent historic mental health experiences and cultural construction of mental health within this population. Educating the community on mental health issues in culturally responsive ways, providing cultural competency trainings for service providers, and development of culturally tailored interventions that go beyond treatment of symptoms to overall healing and well-being are necessary to effectively address the mental health service utilization disparity experienced by the Bhutanese refugee community in central Ohio. This comprehensive effort will be a first step in the right direction to create a socially conducive environment for this population to exercise their rights and flourish as new members of the central Ohio community.

References

- Adhikari, S. B., Yotebieng, K., Acharya, J. N., & Kirsch, J. (2015). Epidemiology of Mental Health, Suicide and Post-Traumatic Stress Disorder among Bhutanese Refugees in Ohio, 2014. Ohio Department of Mental Health and Addiction Services, Community Refugee and Immigration Services. Columbus, Ohio, USA.
- Anderson, R. M. (1995). Revisiting the behavioral model and access to medical care: does it matter? *Journal of Social Behavior*, 36 (3), 1-10.
- An Overview of U.S. Refugee Law and Policy. (2020, January 8). Retrieved March 2, 2020, from <https://www.americanimmigrationcouncil.org/research/overview-us-refugee-law-and-policy>
- Ao, T., Shetty, S., Sivilli, T., Blanton, C., Ellis, H., Geltman, P. L., ... Lopes Cardozo, B. (2016). Suicidal Ideation and Mental Health of Bhutanese Refugees in the United States. *Journal of immigrant and minority health*, 18(4), 828–835. doi:10.1007/s10903-015-0325-7
- Asgary, R., & Segar, N. (2011, May). Barriers to health care access among refugee asylum seekers. Retrieved October 22, 2019, from <https://www.ncbi.nlm.nih.gov/pubmed/21551930>.
- Berry J.W. (2005). Acculturation: living successfully in two cultures. *International Journal of Intercultural Relations*, 29, 697–712. doi: 10.1016/j.ijintrel
- Blizzard, J. B. B., & Batalova, J. (2019, July 2). Refugees and Asylees in the United States. Retrieved March 2, 2020, from <https://www.migrationpolicy.org/article/refugees-and-asylees-united-states>
- Burger, W. R. (2014). Human services in Contemporary America (9 ed.): Brooks/Cole, Cengage Learning.
- Center for Disease Control and Prevention. (2012). An investigation into suicides among Bhutanese refugees in the US 2009 –2012: Stakeholders report. Retrieved from http://www.refugeehealthta.org/files/2012/10/Bhutanese-Suicide-Stakeholder-Report_October_22_2012_Cleared_For_Dissemination1.pdf
- Cochran, J., Geltman, P. L., Ellis, H., Brown, C., Anderton, S., Montour, J, et al. (2013). Suicide and suicidal ideation among Bhutanese refugees—United States, 2009–2012. *Morbidity and Mortality Weekly Report* 62(26):553-6.
- Creswell, J.W. (2015). A Concise Introduction to Mixed Methods Research. Washington DC: Sage Publications.
- Derr A. S. (2016). Mental Health Service Use Among Immigrants in the United States: A Systematic Review. *Psychiatric services* (Washington, D.C.), 67(3), 265–274. <https://doi.org/10.1176/appi.ps.201500004>
- Ellis, B.H., Hulland E.N., Miller, A.B., Bixby, C.B., Cardozo, B.L., Betancourt, T.S. (2016). Mental health risks and resilience among Somali and Bhutanese refugee parents. Washington, DC: Migration Policy Institute.
- Evans, R. (2010). The perils of being a borderland people: On the Lhotshampas of Bhutan. *Contemporary South Asia*, 18(1), 25–42. doi:10.1080/09584930903561598
- Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. *The Lancet*, 365, 1309 –1314. [http://dx.doi.org/10.1016/S0140-6736\(05\)61027-6](http://dx.doi.org/10.1016/S0140-6736(05)61027-6)
- Fetters, M.D., Curry, L.A. and Creswell, J.W. (2013) 'Achieving integration and mixed methods designs—Principles and practices'. *Health Services Research*, 6(2), pp.

2134-2156.

- Fitzgerald, Hayley, "Barriers to mental health treatment for refugees in Maine : an exploratory study" (2017). Masters Thesis, Smith College, Northampton, MA. <https://scholarworks.smith.edu/theses/1892>
- Fortuny, K., & Chaudry, A. (2011). A comprehensive review of immigrant access to health and human services. Washington, DC: Urban Institute
- Greenberg, E., & Fejzic, A. (2019). Immigrant and Refugee Mental Health. Retrieved March 4, 2020, from <https://interface.williamjames.edu/topic/immigrant-refugee-mental-health>
- Hameed, S., Sadiq, A., & Din, A. U. (2018). The Increased Vulnerability of Refugee Population to Mental Health Disorders. *Kansas journal of medicine*, 11(1), 1–12.
- Hutt, M. (2003). Unbecoming citizens: Culture, nationhood, and the flight of refugees from Bhutan. New Delhi, India: Oxford University Press.
- International Organization for Migration (2008). Cultural Profile: The Bhutanese refugees in Nepal: A toolkit for settlement workers and sponsors. Damak, Nepal: Author
- Kaiser Family Foundation. (2013). Key facts on health coverage for low-income immigrants today under the Affordable Care Act.
- MacDowell, H., Pyakurel, S., Acharya, J., Morrison-Beedy, D., & Kue, J. (2020, March). Perceptions Toward Mental Illness and Seeking Psychological Help among Bhutanese Refugees Resettled in the U.S. Retrieved May 1, 2020, from <https://www.ncbi.nlm.nih.gov/pubmed/31599662>
- Maleku, A., Kagotho, N., Karandikar, S., Mengo, C., Freisthler, B., Baaklini, V & Filburn, C. (2018). The New Americans Project: Assessing the Human Service Landscape in Central Ohio. Columbus, Ohio: The Ohio State University College of Social Work
- Maleku, A., Kagotho, N., Baaklini, V., Filburn, C., Karandikar, S., & Mengo, C. (2019). The Human Service Landscape in the Midwestern USA: A Mixed Methods Study of Human Service Equity among the New American Population. *The British Journal of Social Work*, 50(1), 195–221. doi: 10.1093/bjsw/bcz126
- Mills, E., Singh, S., Roach, B., & Chong, S. (2008). Prevalence of mental disorders and torture among Bhutanese refugees in Nepal: A systemic review and its policy implications. *Medicine, Conflict, and Survival*, 24, 5–15. <http://dx.doi.org/10.1080/13623690701775171>
- Mirza, M. Q., Harrison, E. A., Chang, H.-C., Salo, C. D., & Birman, D. (2017). Community perspectives on substance use among Bhutanese and Iraqi refugees resettled in the United States. *Journal of Prevention & Intervention in the Community*, 46(1), 43–60. doi: 10.1080/10852352.2018.1385956
- Morris, M.D., Popper, S.T., Rodwell, T.C., Brodine, S.K., & Brouwer, K.C. (2009). Healthcare barriers of refugees post-resettlement. *Journal of Community Health*, 34, 529-538
- Oliver, B. D. (2014, August). Bhutanese Refugees' Health Behaviors and Perceptions: A Qualitative Approach to Understanding to Bhutanese Refugees' Post-Resettlement Experiences with Healthcare Services in Middle Tennessee. Retrieved October 22, 2019, from https://jewlscholar.mtsu.edu/bitstream/handle/mtsu/4288/Oliver_mtsu_0170E_10299.pdf?sequence=1&isAllowed=y.

- Perreira, K. M., Crosnoe, R., Fortuny, K., Pedroza, J., Ulvestad, K., Weiland, C., Chaudry, A. (2012). Barriers to immigrants' access to health and human services programs. ASPE Issue Brief. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation.
- Saechao, F., Sharrock, S., Reicherter, D., Livingston, J. D., Aylward, A., Whisnant, J., ... & Kohli, S. (2012). Stressors and barriers to using mental health services among diverse groups of first-generation immigrants to the United States. *Community Mental Health Journal*, 48(1), 98-106.
- Saldana, J. (2016). *The Coding Manual for Qualitative Researchers*. London: Sage Publications.
- Schock K, Bottche M, Wenk-Ansohn M, Knaevelsrud C. (2016). Impact of new traumatic or stressful life events on pre-existing PTSD in traumatized refugees: Results of a longitudinal study. *Eur J Psychotraumatol*, 7, 32106
- Shannon, P. J., Wieling, E., Simmelink-Mccleary, J., & Becher, E. (2014). Beyond Stigma: Barriers to Discussing Mental Health in Refugee Populations. *Journal of and Trauma*, 20(3), 281–296. doi: 10.1080/15325024.2014.934629
- Shrestha, D. D. (2015). Resettlement of Bhutanese refugees surpasses 100,000 mark. Retrieved from <http://www.unhcr.org/en-us/news/latest/2015/11/564dded46/resettle-ment-bhutanese-refugees-surpasses-100000-mark.html>
- United Nations High Commissioner for Refugees (UNHCR, 2017). Global Trends on Forced Displacement in 2016. Available <http://www.unhcr.org/en-us/statistics/unhcrstats/5943e8a34/global-trends-forced-displacement-2016.html>
- U.S. Department of State, BPRM Refugee Processing Center, PRM Admissions Graph Dec 31, 2019, <https://www.wrapsnet.org/documents/Graph%20Refugee%20Admissions%20as%20of%2012-31-19.pdf>.
- van der Boor, C.F., White, R. Barriers to Accessing and Negotiating Mental Health Services in Asylum Seeking and Refugee Populations: The Application of the Candidacy Framework. *Journal of Immigrant Minority Health* 22, 156–174 (2020). <https://doi.org/10.1007/s10903-019-00929-y>
- Van Ommeren, M., de Jong, J. T. V. M., Sharma, B., Komproe, I., Thapa, S. B., & Cardeña, E. (2001). Psychiatric disorders among tortured Bhutanese refugees in Nepal. *Archives of General Psychiatry*, 58, 475– 482. <http://dx.doi.org/10.1001/archpsyc.58.5.475>
- Watkins, D.C. (2017). Rapid and rigorous qualitative data analysis: The RADaR technique for applied research. *International Journal of Qualitative Methods*, 16(1):1-9. DOI: 10.1177/1609406917712131

Appendices

Appendix 1

My Experience as a Researcher

This was my first experience as a researcher and it was a learning curve. I knew from the very beginning I wanted to conduct a mixed-methods study, but never fully understood how much time and effort it required. Completing all the work and steps involved for this study taught me so much about my work ethic and myself. The lessons I learned in time management, collaborating well with others, and working alongside the Bhutanese refugee community in central Ohio was an incredible experience for me. This experience is something I will carry with me into my future endeavors.

I hope to attend law school after graduation and my experience as a researcher confirmed my passion for policy reform and human rights. I was able to take what I learned from the classroom and integrate it into my research process. This experience allowed me to collect and examine the data that clearly states that there is a need for change at an institutional level, which is something we always discuss in class but to see the physical proof of quantitative data and statistics as well as the value of qualitative data were incredibly valuable to me. This experience has added much more to my undergraduate experience. I am glad I took on this challenge and I am proud to say this was a worthwhile learning experience.

Appendix 2

IRB approval

03/25/2020

Study Number: 2019B0535

Study Title: Barriers and Facilitators to Mental Health Services for Bhutanese Refugees in Central Ohio: A Mixed Methods Study

Principal investigator: Arati Maleku

Date verified complete: 03/25/2020

Dear Arati Maleku,

Your research submission referenced above has been forwarded for IRB review.

- If the submission requires expedited review, the submission will be posted to an IRB member.
- If the submission requires review by the convened IRB, it will be placed on the next available meeting agenda.

Once your submission has received review, you will be notified of approval or any outstanding requirements requiring your attention.

Thank you,

Jessica Mayercin-Johnson

mayercin-johnson.1@osu.edu

(614) 688-1059



Appendix 3

Survey Instrument

A. Demographic Information (Please check one option)

1. Age

- ☐ Between 20 to 30 years ☐ Between 31 to 40 years
☐ Between 41 to 50 years ☐ Between 51 to 60 years
☐ Between 61 to 70 years ☐ Above 70 years

2. Gender:

- ☐ Male ☐ Female ☐ Other (specify) _____

3. What is your highest level of education?

- ☐ High school diploma or equivalent ☐ Diploma or equivalent
☐ Some college, but no degree ☐ Associate' s degree
☐ Bachelor' s degree ☐ Master' s degree
☐ Doctoral degree or equivalent

4. How long have you been in the US? (in years)

- ☐ 1 Less than 1 year ☐ 2 - Between 1 and 3 years
☐ 3 - Between 3 and 5 years ☐ 4 - Between 5 and 7 years
☐ 5 - Between 7 and 9 years ☐ 6 - 10 years or more

5. How long have you lived in the central Ohio region?

- ☐ 1 Less than 1 year ☐ 2 - Between 1 and 3 years
☐ 3 - Between 3 and 5 years ☐ 4 - Between 5 and 7 years
☐ 5 - Between 7 and 9 years ☐ 6 - 10 years or more

6. Marital Status

- ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Co-habiting

7. Do you have full time employment?

- ☐ Yes ☐ No ☐ other: _____

8. What is your English language skills level?

	very poor	poor	fair	good	excellent
Speaking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Listening	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Writing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. Place of birth: ☐ Bhutan ☐ Nepal ☐ USA ☐ Other: (specify)_____

10. How long have you lived in the United States?

- ☐ Less than 5 years ☐ Between 5 to 10years
☐ Between 10 to 15 years ☐ Between 15 to 20 years
☐ More than 20 years

11. How long have you lived in Central Ohio?

- ☐ Less than 5 years ☐ Between 5 to 10years
☐ Between 10 to 15 years ☐ Between 15 to 20 years
☐ More than 20 years

B. Mental Health

12. Is mental health important to you?

- ☐ Yes ☐ No ☐ Other (specify)_____

13. What does mental health mean to you? Check all that apply.

- ☐ physical wellness ☐ emotional wellness
☐ spiritual wellness ☐ social wellness
☐ clinical ☐ other (specify): _____

14. Do you think members in the Bhutanese community experience mental health problems?

- ☐ Most Definitely ☐ Definitely ☐ Not sure ☐ Not likely ☐ Not at all

15. Is there stigma surrounding mental health within the Bhutanese population? Put a check next to the corresponding answer.

- ☐ Yes ☐ No

16. Do you experience mental health problems?

- ☐ Most Definitely ☐ Definitely ☐ Not sure ☐ Not likely ☐ Not at all

17. Over the **last 2 weeks**, how often you have been bothered by any of the following? Please read each statement carefully and put an “x” in the box to indicate how much you have been bothered by that problem. Only check one box per statement.

GAD-7	None of the time	A little of the time	Some of the time	Most of the time
1. Feeling nervous anxiety or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Being so restless that it is hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Feeling afraid as if something awful might happen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. Over the **last 2 weeks**, how often you have been bothered by any of the following? Please read each statement carefully and put an “x” in the box to indicate how much you have been bothered by that problem. Only check one box per statement.

PHQ-9	None of the time	A little of the time	Some of the time	Most of the time
1. Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Moving or speaking so slowly that other could have noticed? Or the opposite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. Support Seeking [Coping Strategy Indicator Scale]: (select one option per statement)

How often do you seek the following support? Select one option per statement	Not at all	A little	A lot
1. Described your feelings to a friend	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Accepted sympathy and understanding from someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Talked to people about the situation because talking about it made you feel better	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Talked about fears and worries to a relative or friend	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Told people about the situation because talking about it helped you come up with solutions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Went to a friend to help you feel better about the problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Went to a friend for advice about how to change the situation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Went to a friend for advice about how to change the situation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Accepted sympathy and understanding from friends who had the same problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Accepted help from a friend or relative	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Sought reassurance from those who know you best	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

C. Mental Health Service Utilization

20. If experiencing mental health problems, what are you more likely to do?
seek help from your community or mental healthcare providers? Put a check next to the corresponding answer.

☐ Help from community ____ ☐ Help from providers ____ Other (specify)_____

21. Are there services available? Put a check next to the corresponding answer.

☐ Yes____ ☐ No____

22. Are these services easily accessible to you? Put a check next to the corresponding answer.

☐ Yes____ ☐ No____

D. Focus Group Discussion:

23. A second phase of the study will be a focus group discussion. Are you interested to participate in the focus group discussion?

☐ Yes____ ☐ No____

24. If yes, how can we contact you?

Appendix 4

Focus Group Guide

Virtual Focus Group Questions

1. How do you think the Bhutanese community defines mental health?
2. What are your thoughts around the issue of mental health among the Bhutanese refugee community in central Ohio?
3. How do people cope with mental health within the community? (cultural ways of coping)

Probe: How are these cultural ways of coping helping the community?

4. What are the barriers to accessing mental health services in the Bhutanese community?
5. Talking about mental health service utilization, what would help the Bhutanese community access or utilize mental health services?
6. Are there any other comments regarding mental health you would like to share?

Thank you for your participation. As a small gift for your time, I will be sending you a \$25 amazon gift card via email.